

Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

DATE OF MEDICATION REQUEST: / /														
SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED														
LAST NAME:	FIRST NAME:													
MEDICAID ID NUMBER:	DATE OF BIRTH:													
] _			_								
GENDER: Male Female														
Drug Name:	Strength:													
Dosing Directions:	Length of Therapy:													
SECTION II: PRESCRIBER INFORMATION														
LAST NAME:	FIRST NAME:													
SPECIALTY:	NPI NUMBER:													
PHONE NUMBER:	FAX NUMBER:													
				_				_						
SECTION III: CLINICAL HISTORY														
 Does the patient have a confirmed diagnosis of mild Alzheimer's Disease or mild Alzheimer's Disease? 	cogniti	ve im	pairr	nent	(MCI) due	e to			Ye	es [] No		
 Clinical Dementia Rating (CDR) – Global Score 	of 0.5	to 1 [Ye	es 🗌	No									
Objective evidence of cognitive impairment a	t scree	ning	Y	es 🗌	No									
Mini-Mental Status exam (MMSE) score betw	een 22	and	30 (ir	nclus	ive) [Ye	es 🗌] No						
 Positron Emission Tomography (PET) is positive 	ve for b	eta a	mylc	id pl	aque	or								

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

to confirm diagnosis Yes No

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101

cerebrospinal fluid assessment of amyloid beta (1-42) or FDA-approved test



Review Date: 06/29/2023



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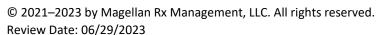
PATIENT LAST NAME: PA													PATIENT FIRST NAME:													
2.	2. Have the following conditions been ruled out: vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus?] Ye:	s [No							
3. Has the patient had a stroke or transient ischemic attack or unexplained loss of consciousness in the past 12 months?														n [] Ye:	s [No									
4. Has the patient had a brain hemorrhage, bleeding disorder, cerebrovascular abnormality, or cardiovascular conditions (e.g., unstable angina, myocardial infarction, advanced congestive heart failure, clinically significant conduction abnormalities) in the past 12 months?] Ye	s [No								
5. Is the patient on an anti-platelet, anticoagulant, or anti-thrombin medication?																Ye	s [No								
6.	6. Is the prescriber a neurologist or gerontologist or has a neurologist or gerontologist been consulted?] Ye:	s [No								
7. Has the patient received a baseline magnetic resonance imaging (MRI) within the past 12 months?] Ye:	s [No									
8. (Aduhelm® only): Will the patient receive a brain MRI prior to the 5 th , 7 th , 9 th , and 12 th doses?															Ye	s [No									
9.	(L	eqe	emb	oi® c	nly):	: Wi	ill th	e pat	tient	rece	ive a	brai	n MR	l pr	ior to	the	5 th , 7	^{rth} , ar	nd 14	th do	ses?			Ye	s [No
 10. Has the patient experienced any of the following? Pre-treatment localized superficial siderosis ≥ 10 brain microhemorrhages 														Ye	s [No										
11.	 Brain hemorrhage > 1 cm Has a baseline assessment been completed with at least one of the following? MMSE Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAP-Cog-13] Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI] Clinical Dementia Rating-Sum of Boxes [CDR-SB] 															Ye	s [] No								
12.				-					-				know		-		l risk	s and	l min	imal	estab	lishe	d [] Ye	s [No

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Magellan Rx MANAGEMENTSM



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 13. For renewals (every 6 months): Has the patient demonstrated stability, improvement, or slowed rate of progression in one of the following assessments? ADAS-Cog 13 ADCS-ADL-MCI MMSE CDR-SB Renewal assessment results: 	d Yes No												
14. Has the patient progressed to moderate or severe Alzheimer's Disease?	Yes No												
15. Has the patient continued dosing at 10 mg/kg every 4 weeks (Aduhelm®) or every 2 weeks (Leqembi™)?													
16. Has the patient received ongoing MRI monitoring as directed in the package insert (questions 8 or 9 above)?													
17. Did the MRI show > 10 new incident microhemorrhages or ≥ 2 focal areas of superficial siderosis?	Yes No												
18. Will a follow-up MRI be performed to assess stability?	Yes No												
19. Do the benefits outweigh the risks based on the MRI results?	Yes No												
Please provide any additional information that would help in the decision-making process. If addition needed, please use a separate sheet.	onal space is												

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PATIENT LAST NAME:											7	PATIENT FIRST NAME:												
I cert	tify that	t the i	inform	natio	n pro	vide	d is	accu	rate	and	cor	nplet	e to	the b	est o	of my	/ kno	wled	lge aı	าd I น	ınder	stand		
that	any fals	sificat	ion, o	missi	ion, c	or co	ncea	alme	nt o	f mat	teri	al fac	t ma	y sul	oject	me t	o civ	il or	crimi	nal li	abilit	y.		
PRESCRIBER'S SIGNATURE:																	DA	ATE: _						
Facil	ity whe	re inf	usion	is to	be p	rovid	led:																	
Med	icaid pr	ovide	r nur	her (of fac	rilitv	•																	
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