LOUISIANA MEDICAID
DONANEMAB-AZBT (KISUNLA™) CLINICAL AUTHORIZATION FORM

SECTION I – SUBMISSION

Submitted to:	Phone:	Fax:	Date:

SECTION II – PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	Zip Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III – PATIENT INFORMATION

Last Name, First Name MI:	DOB:	FFS LA Medicaid ID# or CCN:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
MCO Plan Name (if applicable):	MCO Plan Member ID#:	Plan Provider ID:	

EPSDT Support Coordinator contact information, if applicable:

SECTION IV – PRESCRIPTION DRUG INFORMATION

Requested Drug Name: DONANEMAB-AZBT (KISUNLA™)

This request is for: _____Initiation of treatment _____Continuation of treatment

SECTION V – PATIENT CLINICAL INFORMATION

Does the patient have a diagnosis of Alzheimer's disease? ____Yes ____No If yes, date diagnosed_____
Specify severity of cognitive impairment / dementia _____Mild Cognitive Impairment
_____Mild Dementia
_____Moderate Dementia
_____Severe Dementia

Was the presence of beta-amyloid plaques confirmed by one of the following?
Positron emission tomography (PET) scan ____Yes ____No If yes, date of test_____
Cerebrospinal fluid (CSF) testing ____Yes ____No If yes, date of test_____
Prescriber Initials:_____

SECTION VI – FOR INITIATION OF THERAPY REQUESTS ONLY

Document objective evidence of mild cognitive impairment or mild dementia due to Alzheimer's disease below. [Both are required.]

Score	Date	Name of Test
		Clinical Dementia Rating-Global Score (CDR-GS)
		Mini-Mental State Exam (MMSE)

Specify tool used to document baseline disease severity. **[Note: Same tool MUST be used for baseline assessment and for ongoing assessments.]**

Score	Date	Name of Test
		Alzheimer's Disease Assessment Scale – Cognitive Subscale (ADAS-Cog-13 OR ADAS-Cog-14)
		Clinical Dementia Rating – Sum of Boxes (CDR-SB)
		Montreal Cognitive Assessment (MoCA)
		Repeatable Battery for Assessment of Neuropsychological Status (RBANS)
		Other:_____ *[Name of tool and defining parameters for disease severity for this tool must be included.]*

Does the patient have any contraindication to MRI? ____Yes ____No If yes, explain_____

Most recent magnetic resonance imaging (MRI) Date_____

Please initial below to confirm the results of the MRI:

Were there any findings of > 1 area localized superficial siderosis? ____Yes ____No Prescriber Initials:_____

Were there findings of ≤ 4 brain microhemorrhages? ____Yes ____No Prescriber Initials:_____

Were there finding of any brain hemorrhages > 1 cm within the past year? ____Yes ____No Prescriber Initials:_____

Have other causes of cognitive impairment been ruled out (including, but not limited to, alcohol/substance abuse, frontotemporal dementia (FTD), Lewy body dementia (LBD), Parkinson's disease dementia, unstable psychiatric illness, and vascular dementia)?
____Yes ____No

SECTION VII– FOR CONTINUATION OF THERAPY REQUESTS ONLY

Date of treatment initiation_____ Number of doses since initiation_____

Provide the date of the most recent MRI:_____ [See criteria for MRI recommendations.]
Note: It is recommended that practitioners use the same MRI device with the same imaging protocol for a given patient whenever possible to assist in comparing the images.

For continuation of therapy requests, current clinical symptom severity and MRI findings must be noted below:

ARIA-E clinical symptom severity: _____None _____Mild _____Moderate _____Severe
ARIA-E radiographic severity: _____None _____Mild _____Moderate _____Severe
ARIA-H clinical symptoms: _____Yes _____No
ARIA-H radiographic severity: _____None _____Mild _____Moderate _____Severe

Has the patient progressed to the moderate or severe stage of Alzheimer's disease? ____Yes ____No

Since baseline assessment, has the patient had a **POSITIVE CLINICAL RESPONSE** to treatment demonstrated by assessment with the same validated tool that was used to establish baseline disease severity? ____Yes ____No

Name of tool used to assess baseline disease severity AND ongoing assessments _____

Date of baseline assessment_____ Score_____

Date of most recent follow-up assessment_____ Score_____

SECTION VIII – ADDITIONAL CLINICAL INFORMATION

PHARMACY INFORMATION (OPTIONAL)

Pharmacy Name:	Pharmacy Address:	Phone:

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber:_____ Date:_____

(Proxy signatures are not accepted)