LOUISIANA MEDICAID
ADUCANUMAB-AVWA (ADUHELM™) 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: Aducanumab-avwa (Aduhelm™)

Titration Dosing	**Maintenance Dosing**	**Other**
_____1 mg/kg/dose IV q4weeks x 2 doses	_____10 mg/kg/dose IV q4weeks	_____
_____3 mg/kg/dose IV q4weeks x 2 doses		_____
_____6 mg/kg/dose IV q4weeks x 2 doses		_____

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)
		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 localized superficial siderosis? ____Yes ____No Prescriber Initials:_____

Were there findings of less than 10 brain microhemorrhages? ____Yes ____No Prescriber Initials:_____

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

Is the patient currently taking blood thinners (except ≤ 81mg aspirin)? ____Yes ____No

Is the patient ambulatory? ____Yes ____No

Has the patient had a bleeding disorder or cerebrovascular abnormalities (including, but not limited to, stroke or transient ischemic attack [TIA]) in the last 12 months? ____Yes ____No

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

Does the patient have a history of unstable angina, myocardial infarction, advanced chronic heart failure, clinically significant conduction abnormalities or unexplained loss of consciousness within 1 year of treatment initiation? ____Yes ____No

Has the patient had a seizure in the past 3 years? ____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.

Number of new incident microhemorrhages: _____
Number of focal areas of superficial siderosis: _____ Prescriber Initials:_____

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)