HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
Leqembi®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Leqembi® (lecanemab-irmb)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescribing physician a board-certified neurologist or geriatrician from an Alzheimer's Center of Excellence?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of Alzheimer's disease with mild cognitive impairment or mild dementia state of disease as evidenced by ALL of the following? • Presence of amyloid abnormalities and/or presence of amyloid beta pathology as determined by recent (within one year) Positron Emission Tomography (PET) or lumbar puncture • Clinical Dementia Rating-Global Score (CDR-GS) of 0.5 or 1 • Clinical Dementia Rating (CDR) Memory Box score of 0.5 or greater • Mini-Mental Status Examination (MMSE) score of >22 • Objective impairment in episodic memory indicated by at least 1 standard deviation below age-adjusted mean in the Wechsler Memory Scale IVLogical Memory (subscale) II (WMS-IV LMII)	☐	☐	**Please provide documentation**
3. Does documentation include a MRI of the brain within the past year without evidence of ANY the following? • Prior cerebral hemorrhage greater than 1 cm in greatest diameter • Greater than 4 microhemorrhages	☐	☐	**Please provide documentation**

• Superficial siderosis • Vasogenic edema • Cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory • Severe small vessel or white matter disease			
4. Has the member had a trial and failure of BOTH cholinesterase inhibitor (e.g., donepezil, rivastigmine) and memantine?	☐	☐	**Please provide documentation**
5. Does the member have contraindication to amyloid testing (e.g. PET or brain MRI)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th, 7th, and 14th infusions as determined by brain MRI?	☐	☐	**Please provide documentation**
3. Does the member have continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, RBANS delayed memory index score ≤85, and MMSE score ≥24?	☐	☐	**Please provide documentation**
4. Has the member been at least 80% compliant with infusions?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-M047
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024