HEALTH PLANS
UNIVERSITY OF UTAH

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM

MONOCLONAL ANTIBODIES FOR ALZHEIMER'S DISEASE

Kisunla™, Leqembi®

For authorization, please answer each question and fax this form PLUS chart notes back to Medicaid Prior Authorization Department.

- Healthy U: 801-213-1547
- Health Choice Utah: 801-646-7300

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

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 833-981-0212
- Health Choice Utah: 877-358-8797

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: ☐ Kisunla™ (donanemab-azbt), ☐ 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 that specializes in Alzheimer's Disease (AD) treatment?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of AD with mild cognitive impairment or AD with mild dementia AND presence of amyloid abnormalities and/or presence of amyloid beta pathology as determined by PET scan or lumbar puncture within the past 12 months?	☐	☐	**Please provide documentation**
3. Does documentation include an 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 • Superficial siderosis • Vasogenic edema • Cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory	☐	☐	**Please provide documentation**

• 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**
LEQUEMBI			
1. Is the member between the ages of 50 and 90?			
2. Does the member have documentation of all of the following: • Mini-Mental Status Examination (MMSE) score of 22 or greater; and • Clinical Dementia Rating-Global Score of 0.5 or 1; and • Memory Box score of 0.5 or greater; and • Documentation of objective impairment in episodic memory as indicated by at least 1 standard deviation below age-adjusted mean in the Wechsler Memory Scale IV-Logical Memory (subscale) II evaluation?	☐	☐	**Please provide documentation**
KISUNLA			
1. Is the member between the ages of 60 and 85?			
2. Does the member have documentation of a Mini-Mental Status Examination (MMSE) score of 20 or greater?	☐	☐	**Please provide documentation**
LEQEMBI 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?	☐	☐	
KISUNLA 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 2nd, 3rd, 4th, and 7th infusions as determined by brain MRI?	☐	☐	**Please provide documentation**
3. Are PET scans completed at 6, 12, and 18 months from initiation of Kisunla provided showing continued necessity as evidenced by NOT meeting Stopping Criteria? Stopping Criteria includes at least ONE of the following: a. Amyloid plaque level <11 centiloids on a <u>single</u> PET scan, or b. Amyloid plaque level 11 to <25 centiloids on <u>2 consecutive</u> PET scans			**Please provide documentation**
4. Does the member have continued evidence of mild cognitive impairment as evidenced by an updated MMSE score ≥24?	☐	☐	**Please provide documentation**
5. Has the member been at least 80% compliant with infusions?	☐	☐	

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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:	
PRESCRIBER CERTIFICATION	
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.	
Physician's Signature:	**Date:**

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Policy: PHARM-MM-M047
Origination Date: 08/09/2023
Reviewed/Revised Date: 07/25/2025
Next Review Date: 07/25/2026
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