

**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Aduhelm**



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____
Address _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

1. Does the beneficiary have mild cognitive impairment due to Alzheimer's Disease or mild Alzheimer's Dementia? Yes No
2. Has the beneficiary received all of the tests listed below?
 - a. Clinical Dementia Rating (CDR) -Global Score of 0.5 Yes No
 - b. Objective evidence of cognitive impairment at screening Yes No
 - c. Mini-Mental Status Exam (MMSE) score between 24 and 30 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient) Yes No
 - d. Positron Emission Tomography (PET) scan is positive for amyloid beta plaque or Cerebrospinal Fluid Test (collected via lumbar puncture) is positive for amyloid Yes No
3. Is the beneficiary age 50 or older? Yes No
4. Has the beneficiary undergone testing to rule out reversible causes of dementia Yes No
5. Has the beneficiary had an assessment including a review of current medications as a cause of intellectual decline? Yes No
6. Has the beneficiary had a recent (within one year) brain MRI prior to beginning treatment? Yes No
7. Has the Prescriber has assessed and documented baseline disease severity utilizing an objective measure/tool? Yes No
8. Does the Beneficiary does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis? Yes No
9. Has the beneficiary had a failure of or inability to tolerate at least one other preferred cholinesterase inhibitor Alzheimer therapy for at least four months? Yes No Please List _____
10. Does the provider attests to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)? Yes No
11. Does the beneficiary have hypersensitivity to any components of Aduhelm™? Yes No
12. Is Aduhelm™ being prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.