NEBRASKA MEDICAID & LONG-TERM CARE
Lequembi (lecanemab-irmb)
Prior Authorization Form for Fee-for-Service

Patient Name: _____Patient ID: _____
Patient Date of Birth: _____
Ordering physician (print): _____ NPI _____
(prescribed by or in consultation with a neurologist or geriatrician specialist in the treatment of dementia or Alzheimer's disease.
Phone _____ Physician's Fax Number _____

HCPCS code _____ units_____ Dose/frequency/duration _____

Diagnosis Code: _____ Date of last dose (if reauthorization) _____

Section I: Please complete for <u>INITIAL REQUEST.</u> The initial authorization period is for 6 months.

1. Indication
   Alzheimer's disease (Specify stage of disease):
   ___ Mild cognitive impairment
   ___Mild dementia

2. Is the prescriber a neurologist or geriatrics specialist?
   Yes __
   No. Please attach consultation notes from a neurologist or geriatrics specialist addressing the use of the requested agent.

3. Please provide baseline (within the past three months) score of one of the following tests:
   Mini Mental State Exam (MMSE) (attach a copy of MMSE) Date_____ Score_____
   Montreal Cognitive Assessment (MoCA) (attach a copy of MoCA) Date _____Score_____
   Saint Louis University Mental Status Examination (SLUMS) Date _____Score_____
   Clinical Dementia Rating-Global Score (CDR-GS) Date _____ Score____

4. Does the patient have confirmed evidence of clinically significant Alzheimer's disease (AD) neuropathology based on one of the following? (circle one) If yes, please attach supporting documentation.

   Yes, based on Cerebral Spinal Fluid (CSF) biomarkers. ___
   Yes, based on Amyloid positron emission tomography (PET). ___
   No ___

5. Has the patient had a brain magnetic resonance imaging (MRI) in the previous twelve months?
   Yes __ Date _____
   No __

6. Is the patient currently on other amyloid beta-directed antibody therapies?
   Yes___ No___ If yes, please explain:

_____
_____

Section II: Please complete for RENEWAL REQUEST. The re-authorization period is for 6 months.
Dose Number_____

ALL of the following are required:

1. Does the patient continue to have ONE of the following? Indicate which one.
   Mild cognitive impairment (MCI) due to Alzheimer's Disease ___
   Mild dementia associated with Alzheimer's Disease ___

2. Is the prescriber a neurologist, or geriatrics specialist in the treatment of dementia or Alzheimer's Disease?
   Yes __
   No. Please attach consultation notes from a neurologist or geriatrics specialist addressing the use of the requested agent.

3. Has the patient had all MRI monitoring for evidence of amyloid related imaging abnormalities (ARIA) prior to the:

   5th dose: Yes ____ No ___

   7th dose: Yes ___ No _____

   14th dose: Yes _____ No ____

   Date of last MRI_____

4. Has the patient had a positive clinical response as evidenced by stabilization or slowing of disease progression using the same assessment tool submitted for initial authorization, with current (within last three months) cognitive function based on ONE of the following:

   Mini Mental State Exam (MMSE) Date _____ Score _____
   Montreal Cognitive Assessment (MoCA) Date _____ Score _____
   Saint Louis University Mental Status Examination (SLUMS) Date_____ Score _____
   Clinical Dementia Rating-Global Score (CDR-GS) Date _____ Score _____

* Please attach additional information as applicable.

Prescribing Practitioner's Signature: _____Date _____

Submit this form and medical records to:

Nebraska Medicaid Pharmacy Program Specialist
FAX: (402) 471-9103
eFAX: (402) 472-1104 or
Mail to: P.O. Box 95026 Lincoln, NE 68509