Clinical Criteria Worksheet:
Aduhelm® (aducanumab)

Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug or it will be rejected for not enough documentation.

Enrollee Information

Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY):

/ /

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

Address:

City, Town or Post Office:

State:

ZIP Code:

Prescriber Information

Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number:

Preferred Contact (Telephone Number)

– –

Enrollee Last Name:

Enrollee First Name:

Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

/ /

Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

/ /

Drug Name and Strength:

☐ Aduhelm® 100 mg/mL

Patient's Current Weight: _____ kg

New treatment: ☐ Yes ☐ No

If **No**, date therapy initiated (MM/DD/YYYY):

/ /

Infusion number (please select one):

☐ Infusions 1 and 2: 1 mg/kg

☐ Infusions 3 and 4: 3 mg/kg

☐ Infusions 5 and 6: 6 mg/kg

☐ Infusions 7 and beyond: 10 mg/kg

Calculated dose for administration: _____mg

Quantity of vials needed for infusion: _____

Clinical Criteria – Initiation of Therapy

1. Was a baseline magnetic resonance imaging (MRI) performed within 1 year before initiating treatment, demonstrating that the patient did ***not*** have pre-treatment localized superficial siderosis, 4 or more brain microhemorrhages, or brain hemorrhage greater than 1 cm?

   ☐ Yes ☐ No

Enrollee Last Name:

Enrollee First Name:

2. Does the member have a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild AD confirmed by a dementia assessment tool?

   ☐ Yes ☐ No

   Please select the assessment tool used:

   ☐ Clinical Dementia Rating (CDR) - Please indicate score:_____

   ☐ Mini-Mental Status Exam (MMSE) - Please indicate score:_____

   ☐ Montreal Cognitive Assessment (MoCA) - Please indicate score:_____

   ☐ Other tool: _____ Please indicate score:_____

3. Does the patient have evidence of any medical or neurological condition other than Alzheimer's Disease that might be a contributing cause of the patient's cognitive impairment?

   ☐ Yes ☐ No

4. Were amyloid beta deposits found in a positron emission tomography (PET) scan or a cerebrospinal fluid (CSF) analysis?

   ☐ Yes ☐ No

   Was the result of the PET scan or CSF analysis submitted with this request confirming the presence of amyloid beta deposits in the brain?

   ☐ Yes ☐ No

5. Was genetic testing performed to assess apolipoprotein E (ApoE) ε4 carrier status?

   ☐ Yes ☐ No

   Was the result of genetic testing to assess apolipoprotein E (ApoE) ε4 carrier status submitted with this request?

   ☐ Yes ☐ No

6. Does the patient have a history of a clotting disorder?

   ☐ Yes ☐ No

7. Is the patient taking any form of antiplatelet or anticoagulant medications other than aspirin less than or equal to 325 mg per day?

   ☐ Yes ☐ No

Enrollee Last Name:

Enrollee First Name:

Clinical Criteria – Continuation of Therapy

1. Utilizing the patient's same baseline dementia assessment tool, has the patient's assessment score remained stable or improved?

   ☐ Remained stable ☐ Improved ☐ No

   Please select the assessment tool utilized:

   ☐ Clinical Dementia Rating (CDR)

   ☐ Mini-Mental Status Exam (MMSE)

   ☐ Montreal Cognitive Assessment (MoCA)

   ☐ Other: _____

2. Was an MRI completed before the 5th infusion (first dose 6 mg/kg); 7th infusion (first dose of 10 mg/kg); 9th infusion (third dose of 10 mg/kg); and 12th infusion (sixth dose of 10 mg/kg) to monitor for amyloid related imaging abnormalities (ARIA)?

   ☐ Yes ☐ No

3. Have any of the following changes developed since the last dose?

   ☐ Evidence of any medical or neurological condition other than Alzheimer's Disease that might be a contributing cause of the patient's cognitive impairment

   ☐ A diagnosis of a clotting disorder

   ☐ Initiation of anticoagulant or aspirin therapy greater than 325 mg per day

   ☐ No changes since the last dose

Attestation

I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required) **Date (MM/DD/YYYY)**