



Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race Ethnicity

Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan

MassHealth Drug Utilization Review Program
Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

Fallon Health
Online Prior Authorization: go.covermy meds.com/OptumRx
Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum
Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

Health New England
Online Prior Authorization: go.covermy meds.com/OptumRx
Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

Mass General Brigham Health Plan
Online Prior Authorization (Pharmacy Benefit Reviews): go.covermy meds.com/OptumRx
Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org
Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

Tufts Health Plan
Online Prior Authorization: point32health.promptpa.com
Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

WellSense Health Plan
Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations
Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Anti-Amyloid Monoclonal Antibodies Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Medication information

Medication requested

- Kisunla (donanemab-azbt)
 Leqembi (lecanemab-irmb)
 Leqembi Iqlik (lecanemab-irmb)

Dose, frequency, and duration of medication requested

Indication (Check all that apply or include ICD-10 code, if applicable.)

- Alzheimer's Disease (Specify stage of disease.)

Mild cognitive impairment

Mild dementia

Other

Please indicate billing preference. Pharmacy Prescriber in-office Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

Is the prescriber a specialist in the treatment of dementia or Alzheimer's Disease?

Yes

No. Please attach consultation notes from a specialist in the treatment of dementia or Alzheimer's Disease (e.g., neurologist, geriatric psychiatrist, geriatrician who specializes in treating dementia).

Section I. Please complete for initial requests for Kisunla and Leqembi infusion.

Please note testing for ApoE ϵ 4 status should be performed prior to initiation of treatment to inform the risk of developing amyloid related imaging abnormalities (ARIA). ApoE ϵ 4 genotyping is covered with prior authorization obtained through the Provider Online Service Center (POSC).

1. Please provide baseline (within the past three months) score of one of the following tests.

Mini Mental State Exam (MMSE)

Date

Montreal Cognitive Assessment (MoCA)

Date

Saint Louis University Mental Status Examination (SLUMS)

Date

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

Yes, based on Cerebral Spinal Fluid (CSF) biomarkers. Please attach supporting documentation.

Yes, based on Amyloid positron emission tomography (PET). Please attach supporting documentation.

No

3. Has the member had a brain magnetic resonance imaging (MRI) in the previous 12 months?

Yes. Date

No

4. For Kisunla, has the member had a trial with Leqembi?

Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.

Dose and frequency Dates/duration of use

Did the member experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

No. Please describe why Leqembi is not appropriate for this member.

Section II. Please complete for initial requests for Leqembi Iqlik.

1. Please provide current (within the past three months) score of one of the following tests.

MMSE Date

MoCA Date

SLUMS Date

2. Has the member been treated with Leqembi IV for at least 18 months? Yes No

3. Has all MRI monitoring been completed in accordance with the FDA-approved label?

Yes. Please describe.

No

Section III. Please complete for all recertification requests.

1. Has the member had follow-up MRIs completed in accordance with the FDA-approved label?

Yes. Please describe.

No

2. Please provide most recent score and date administered for one of the following tests.

MMSE Date

MoCA Date

SLUMS Date

3. For Leqembi infusion, after completion of 18 months of treatment, is the requested dose every four weeks?

Yes

No. Please provide clinical rationale for requested dose.

Section III. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name Dates/duration of use

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the healthcare provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)