Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

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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.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Dose, frequency, and duration of medication requested _____

Indication

☐ Alzheimer's disease (Specify stage of disease.)

☐ Mild cognitive impairment ☐ Mild dementia ☐ Other _____

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

For hospital outpatient billing, provide department-specific facility NPI. _____

Drug NDC (if known) or service code _____

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.

Section I. Please complete for all requests.

1. Please provide baseline (within the past three months) score of one of the following tests:
   Mini Mental State Exam (MMSE) (please attach a copy of MMSE) _____ Date _____
   Montreal Cognitive Assessment (MoCA) (please attach a copy of MoCA) _____ 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.
   ☐ Yes, based on Amyloid positron emission tomography (PET).
   ☐ No
3. Has the member had a brain magnetic resonance imaging (MRI) in the previous three months?
   ☐ Yes. Date _____ ☐ No
4. Has the member and/or authorized representative been informed of the known and potential risks and lack of established clinical benefit associated with treatment?
   ☐ Yes (Member) ☐ Yes (Authorized Representative) ☐ No

5. Does the member have any of the following neurologic conditions?

Probable dementia with Lewy bodies by consensus criteria	☐ Yes	☐ No
Suspected frontotemporal degeneration	☐ Yes	☐ No
Dementia in down syndrome	☐ Yes	☐ No

6. Does the member have significant cerebrovascular disease as established by brain MRI showing any of the following? (Check all that apply.)

☐ Yes

- ☐ Acute or sub-acute hemorrhage
- ☐ Prior macro-hemorrhage or prior subarachnoid hemorrhage (unless finding is not due to an underlying structural or vascular hemorrhage)
- ☐ Microhemorrhages
  Please provide number. _____
- ☐ Cortical infarct
- ☐ Lacunar infarct
  Please provide number. _____
- ☐ Superficial siderosis
- ☐ History of diffuse white matter disease

☐ No

7. Does the member have any of the following cardiovascular conditions?

Uncontrolled hypertension	☐ Yes	☐ No
Coronary artery disease (including unstable angina and myocardial infarction)	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Clinically significant carotid atherosclerosis and/or peripheral arterial disease	☐ Yes	☐ No
History of stroke (within the past year)	☐ Yes. Date _____	☐ No
History of transient ischemic attack (within the past year)	☐ Yes. Date _____	☐ No
History of unexplained loss of consciousness (within the past year)	☐ Yes. Date _____	☐ No
Coagulopathy	☐ Yes	☐ No
Requirement for therapeutic anticoagulation and/or dual antiplatelet therapy (not including aspirin ≤ 325 mg/day as monotherapy)	☐ Yes	☐ No

8. Please indicate if the member has any of the following chronic medical conditions (Check all that apply and please describe.):

- ☐ Liver disease: _____
- ☐ Pulmonary disease: _____
- ☐ Autoimmune disease requiring chronic immunosuppression: _____
- ☐ Malignant neoplasm: _____
- ☐ Active chronic infection (HIV, HCV): _____
- ☐ Diabetes mellitus: _____
- ☐ Seizure disorder: _____
- ☐ Mood disorder: _____
- ☐ Anxiety disorder: _____
- ☐ Psychosis: _____
- ☐ Other clinically significant condition: _____

If the member has any of the above, is the condition(s) controlled?

☐ Yes. Please explain*. _____

☐ No. Please explain*. _____

Section II. Please complete for recertification requests.

1. Has the member had follow-up MRIs conducted at the following timeframes? (Check all that apply.)

☐ Yes

- ☐ Week 14 (after 4th infusion, prior to first 6 mg/kg dose). Date of MRI _____
- ☐ Week 22 (after 6th infusion, prior to first 10 mg/kg dose). Date of MRI _____
- ☐ Week 30 (after 8th infusion, prior to third 10 mg/kg dose). Date of MRI _____
- ☐ Week 42 (after 11th infusion, prior to sixth 10 mg/kg dose). Date of MRI _____
- ☐ Every six months thereafter. Most recent date of MRI _____

☐ No

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2. Please provide most recent date administered and score of one of the following tests:
   MMSE Score (please attach a copy of MMSE) _____ Date _____
   MoCA Score (please attach a copy of MoCA) _____ Date _____
   For a MMSE score < 24 or MoCA score < 15, was the member's rate of decline slower than expected (< two points/year)?
   ☐ Yes
   ☐ No. Please provide clinical rationale for continuing therapy*. _____
   _____
3. Does the member have new incident Amyloid-related imaging abnormalities-hemosiderin deposition (ARIA-H) microhemorrhages?
   ☐ Yes. Please provide the following information below.
   Please indicate number of new incident microhemorrhage(s). _____
   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
   Has the member's microhemorrhages been stabilized? ☐ Yes ☐ No
   ☐ No
4. Does the member have new incident ARIA-H areas of superficial siderosis?
   ☐ Yes. Please provide the following information below.
   Please indicate number of new incident areas of superficial siderosis. _____
   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
   Has the member's superficial siderosis been stabilized? ☐ Yes ☐ No
   ☐ No
5. Does the member have Amyloid-related imaging abnormalities-edema (ARIA-E)?
   ☐ Yes. Please provide the following information below.
   Does the member have new ARIA-E? ☐ Yes ☐ No
   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
   What is the severity of ARIA-E on MRI? ☐ Mild ☐ Moderate ☐ Severe
   Has the member's ARIA-E been stabilized? ☐ Yes ☐ No
   ☐ No
6. Did the member initiate or develop any of the following? (Check all that apply.)
   ☐ Yes
   ☐ Initiation of anticoagulation
   ☐ Development of active immune-mediated/autoimmune conditions (e.g., Crohn's disease, systemic lupus erythematosus, aplastic anemia, myasthenia gravis, meningitis/encephalitis)
   ☐ Initiation of immunomodulatory medications (e.g., cancer immunotherapies, rituximab, azathioprine)
   ☐ Development of other neurologic conditions (e.g., intracerebral bleeds, traumatic brain injury, stroke)
   If yes, please describe clinical rationale for continued treatment*.
   _____
   _____
   ☐ No

* Please attach a letter documenting additional information as applicable.

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____Date _____