Trillium Health Resources
Pharmacy Prior Approval Request for

Leqembi

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: Leqembi 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Authorization:

1. Is the member age 18 and older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia? ☐ **Yes** ☐ **No**
3. Does the member have a Clinical Dementia Rating (CDR)-Global score of 0.5 to 1? ☐ **Yes** ☐ **No**
4. Does the member have a Memory Box score ≥ 0.5? ☐ **Yes** ☐ **No**
5. Does the member have a Montreal Cognitive Assessment (MoCA) score 18 to 25 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient)? ☐ **Yes** ☐ **No**
6. Does the member have an objective evidence of cognitive impairment at screening? ☐ **Yes** ☐ **No**
7. Does the member have a Positron emission tomography (PET) scan or cerebrospinal fluid (CSF) assessment of amyloid beta (1-42) that is positive for amyloid beta plaque? ☐ **Yes** ☐ **No**
8. Does the prescriber attests other conditions causing similar symptoms have been ruled out (e.g., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus)? ☐ **Yes** ☐ **No**
9. Does the member have risk factors for intracerebral hemorrhage (e.g., prior cerebral hemorrhage > 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel or white matter disease)? ☐ **Yes** ☐ **No**
10. Has the member had a stroke, transient ischemia attack (TIA), or seizure in the last 12 months? ☐ **Yes** ☐ **No**
11. Has the member demonstrated clinically significant and unstable psychiatric illness in the last 6 months? ☐ **Yes** ☐ **No**
12. Is the member currently receiving anti-platelet agents (with the exception of prophylactic aspirin or clopidogrel), anticoagulants (e.g., Factor Xa inhibitors), or anti-thrombins (e.g., heparin)? ☐ **Yes** ☐ **No**
13. Has the member had a recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment? ☐ **Yes** ☐ **No**
14. Has the baseline disease severity been assessed using an objective measure/tool (e.g., MoCA, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living InventoryMild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB])? ☐ **Yes** ☐ **No**
15. Is Leqembi being prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist? ☐ **Yes** ☐ **No**

Re- Authorization: (Please answer 1-15 above and 1- 5 below)

1. Does scoring for the member on an objective measure/tool (e.g., ADAS-Cog 13; ADCS-ADL-MCI; MMSE; CDR-SB) demonstrates improvement, stability, or slowing of decline in cognitive and/or functional impairment? ☐ **Yes** ☐ **No**
2. Has the member progresses to moderate or severe Alzheimer's Disease? ☐ **Yes** ☐ **No**

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3. Has the member experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)? ☐ **Yes** ☐ **No**
4. Has the member undergone Member has undergone MRI prior to the 5th, 7th, and 14th infusions to monitor for ARIA with edema (ARIA-E) or ARIA with hemosiderin deposition (ARIA-H)? ☐ **Yes** ☐ **No**
5. Will Leqembi administrations be suspended and not resumed until MRI demonstrates radiographic resolution and stabilization of symptoms in the event of any of the following? ☐ **Yes** ☐ **No**
   - ARIA-E that is asymptomatic or mildly symptomatic with moderate to severe radiographic severity
   - ARIA-E with moderate to severe symptoms and any degree of radiographic severity
   - ARIA-H that is asymptomatic with moderate radiographic severity
   - ARIA-H with moderate to severe symptoms and any degree of radiographic severity
   - ARIA-H with severe radiographic severity

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.

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