Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Aducanumab (Aduhelm) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

- Is the medication prescribed by or in consultation with a neurologist, geropsychiatrist, geriatrician, or a physician who specializes in the treatment of Alzheimer's disease? **Yes or No**
- What is the member's current weight? _____ lbs or _____kg

Diagnosis: Please select the diagnosis and complete a-g below

□ Mild cognitive impairment
□ Mild dementia stage Alzheimer's disease
□ Other _____

a) Does the member have a mini Mental State Examination (MMSE) scores between 24-29? **Yes or No**
   - If No, what is the MMSE score? _____

b) Does the member have a Clinical Dementia Rating (CDR) global score of 0.5? **Yes or No**

c) Does the member have a positive amyloid Positron Emission Tomography (PET) scan? **Yes or No**

d) Has the member had a recent (within one year) brain MRI prior to initiating treatment? **Yes or No**

e) Does the member have an absence of significant levels of impairment in other cognitive domains? **Yes or No**

f) Does the Provider attest to have an MRI completed prior to the 7th and 12th dose to evaluate for the presence of asymptomatic Amyloid Related Imaging Abnormalities (ARIA)? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

– Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

a) Has the member had improvement or stabilization in any of the following compared to baseline at week 78?

□ Mini Mental State Examination (MMSE) score

□ Clinical Dementia Rating (CDR) score

□ None of the above

b) Has an MRI been done prior to the 7th and 12th dose to evaluate for the presence of asymptomatic Amyloid Related Imaging Abnormalities (ARIA)? **Yes or No**

c) Was radiographic presence of severe ARIA-H observed (10 or more new incident microhemorrhages or more than 2 focal areas of superficial siderosis)? **Yes or No**

- If Yes, was a clinical evaluation and a follow-up MRI performed demonstrating radiographic stabilization (i.e., no increase in size or number of ARIA-H)? *Please submit documentation.*
  Yes or No

d) What is the member's current weight? _____ lbs or _____kg

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**