Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Alzheimer's: Aduhelm

Member Information

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

Prescriber Information

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

Drug Information

1. Drug Name: **Aduhelm** 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 ☐ Other

Clinical Information

1. Does the member have mild cognitive impairment due to Alzheimer's disease or mild Alzheimer's Dementia?
   ☐ **Yes** ☐ **No**
2. Has the member received all of the tests listed below?
   a. Clinical Dementia Rating (CDR) -Global Score of 0.5 ☐ **Yes** ☐ **No**
   b. Objective evidence of cognitive impairment at screening ☐ **Yes** ☐ **No**
   c. Mini-Mental Status Exam (MMSE) score between 24 and 30 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient)
      ☐ **Yes** ☐ **No**
   d. Positron Emission Tomography (PET) scan is positive for amyloid beta plaque or Cerebrospinal Fluid Test (collected via lumbar puncture) is positive for amyloid ☐ **Yes** ☐ **No**
3. Is the member age 50 or older? ☐ **Yes** ☐ **No**
4. Has the member undergone testing to rule out reversible causes of dementia ☐ **Yes** ☐ **No**
5. Has the member had an assessment including a review of current medications as a cause of intellectual decline?
   ☐ **Yes** ☐ **No**
6. Has the member had a recent (within one year) brain MRI prior to beginning treatment? ☐ **Yes** ☐ **No**
7. Has the Prescriber has assessed and documented baseline disease severity utilizing an objective measure/tool?
   ☐ **Yes** ☐ **No**
8. Does the member does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes micro-hemorrhage and superficial siderosis? ☐ **Yes** ☐ **No**
9. Has the member had a failure of or inability to tolerate at least one other preferred cholinesterase inhibitor Alzheimer therapy for at least four months? ☐ **Yes** ☐ **No** Please List:_____
   _____
10. Does the provider attest to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)? ☐ **Yes** ☐ **No**
11. Does the member have hypersensitivity to any components of Aduhelm? ☐ **Yes** ☐ **No**
12. Is Aduhelm being prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist?
    ☐ **Yes** ☐ **No**

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.