LOUISIANA MEDICAID DONANEMAB-AZBT (KISUNLA™) CLINICAL AUTHORIZATION FORM

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SECTION I – S	SUBMISSION								
Submitted to: Ph			Phone:	Phone:		Fax:		Date:	
SECTION II –	PRESCRIBER	INFORMATION	<u>. </u>						
Last Name, First	t Name MI:				NPI# or Pl	an Provider #:	Specialt	:y:	
Address:				City:			State:		Zip Code:
Phone:		Fax:		Office	Contact Name:		Contact Phone:		
SECTION III -	PATIENT INF	ORMATION		I			1		
Last Name, First	Last Name, First Name MI: DOB:			FFS LA Medicaid ID# or CCN:		CCN:	☐ Male		Female Unknown
Address:		•	•		City:		State:		ZIP Code:
MCO Plan Name (if applicable):			М	MCO Plan Member ID#:			Plan Provider ID:		
EPSDT Support	Coordinator cor	ntact information, if	applicable	2:					
SECTION IV -	- PRESCRIPTION	ON DRUG INFOR	MATION	J					
Requested D	rug Name:	DONANEMAB-A	ZBT (KIS	UNLA™)					
This request is f	for:	Initiation of trea	tment	C	ontinuatior	of treatment			
SECTION V -	PATIENT CLI	NICAL INFORMA	TION						
		sis of Alzheimer's di pairment / dementia	aM M M	Yes lild Cognitive lild Dementia loderate Dem evere Dement	mpairmen	es, date diagnos t	ed		
Positron e	mission tomogr	oid plaques confirm aphy (PET) scan uid (CSF) testing	Yes	_No If yes _No If yes	, date of te	st			
SECTION VI -	- FOR INITIAT	ION OF THERAP	Y REQUE	STS ONLY					
Document obje	ctive evidence	of mild cognitive im	pairment	or mild deme	entia due to	o Alzheimer's di	sease below	v. [Both	are required.]
Score	Date	Name of Test							
		Clinical Dementia Rating-Global Score (CDR-GS)							
		Mini-Mental State	Exam (MIV	1SE)					

Specify tool us	ed to document	t baseline disease	e severity. [Note		be used for baseline ass	essential and the subsential assessments.	
Score	Date	Name of Test					
		Alzheimer's Dis	ease Assessmei	nt Scale – Cogni	tive Subscale (ADAS	-Cog-13 OR ADAS-Cog-14)	
		Clinical Dement	ia Rating – Sum	n of Boxes (CDR	-SB)		
		Montreal Cogni	tive Assessmen	nt (MoCA)			
		Repeatable Bat	tery for Assessr	ment of Neurop	sychological Status	(RBANS)	
		Other:					
		[Name of tool o	and defining pa	rameters for dis	sease severity for thi	is tool must be included.]	
Does the patier	nt have any con	traindication to N	MRI?Yes	No If ye	es, explain		
Most recent ma	agnetic resonan	ce imaging (MRI)	Date				
Diagram initial la		4h	- NADI.				
		the results of the		idorosis?	Vos No D	roseribor Initials:	
					YesNo Prescriber Initials:_		
	_			_	_	Prescriber Initials:	
were mer	e illiuling of arry	Dialii Heilloitila	Re2 > 1 CIII MIIII	iiii tile past year	rresNO	Prescriber illitials	
Have other cau), Lewy body de			_		substance abuse, frontotemporal ness, and vascular dementia)?	
Have other cau dementia (FTD) Yes), Lewy body de No		rkinson's diseas	se dementia, un	stable psychiatric ill		
Have other cau dementia (FTD) Yes SECTION VII-	, Lewy body de No – FOR CONTI	mentia (LBD), Pai	rkinson's diseas	QUESTS ONL	stable psychiatric ill		
Have other cau dementia (FTD)Yes SECTION VII-), Lewy body de No - FOR CONTI	Mentia (LBD), Pai	rkinson's diseas	QUESTS ONL	stable psychiatric ill Y of doses since initiat	ness, and vascular dementia)?	
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SECTION VIII – ADDITIONAL CLINICAL INFORMATION						
PHARMACY INFORMATION (OPTIONAL)						
Pharmacy Name:	Pharmacy Address:	Phone:				
By signing this request, the prescriber attests that the knowledge. Also, by signing and submitting this reque						
section of the criteria specific to this request, if applic		ii tile Attestation				
Signature of Prescriber:	Date:					
(Proxy signatures are not	accepted)					