LEQEMBI®
(lecanemab-irmb)

Prior authorization (PA) checklist for LEQEMBI®

The information and common documentation listed below are for informational purposes only and may be helpful when seeking a PA for LEQEMBI. LEQEMBI is available as intravenous infusion 100 mg/mL and subcutaneous injection 200 mg/mL. It is important to review the health plan's guidelines for obtaining a PA, as requirements vary by plan and depend on formulation. Infusion therapies are generally reimbursed under a patient's medical benefit, whereas the subcutaneous formulation is typically processed through the pharmacy benefit. For health-plan–specific criteria or questions regarding insurance processes and access to treatment, please contact the **LEQEMBI Companion™ program**.

Confirming patient benefits

PA requirements vary among plans. Contact the health plan to understand the process, diagnostic requirements, duration of approval, and other relevant information. PA forms may be obtained through the insurer's website or by contacting the insurer's customer service department.

INDICATION

LEQEMBI® is indicated for the treatment of Alzheimer's disease (AD). Treatment with LEQEMBI should be initiated in patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in clinical trials.

IMPORTANT SAFETY INFORMATION

WARNING: AMYLOID-RELATED IMAGING ABNORMALITIES (ARIA)

- **Monoclonal antibodies directed against aggregated forms of beta amyloid, including LEQEMBI, can cause ARIA, characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H). Incidence and timing of ARIA vary among treatments. ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events, including seizure and status epilepticus, can occur. ARIA can be fatal. Serious intracerebral hemorrhages (ICH) >1 cm, some of which have been fatal, have been observed with this class of medications. Because ARIA-E can cause focal neurologic deficits that can mimic an ischemic stroke, consider whether such symptoms could be due to ARIA-E before giving thrombolytic therapy to a patient being treated with LEQEMBI.**
  - **Apolipoprotein E ε4 (ApoE ε4) Homozygotes: Patients who are ApoE ε4 homozygotes (~15% of patients with AD) treated with this class of medications have a higher incidence of ARIA, including symptomatic, serious, and severe radiographic ARIA, compared to heterozygotes and noncarriers. Testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA. Prior to testing, prescribers should discuss with patients the risk of ARIA across genotypes and the implications of genetic testing results. Prescribers should inform patients that if genotype testing is not performed, they can still be treated with LEQEMBI; however, it cannot be determined if they are ApoE ε4 homozygotes and at higher risk for ARIA.**
- **Consider the benefit of LEQEMBI for the treatment of AD and the potential risk of serious ARIA events when deciding to initiate treatment with LEQEMBI.**

Common PA requirements

Patient/provider information

- ☐ Standard demographic information
- ☐ Enrollment in a patient registry
  - CMS requires original Medicare & Medicare Advantage beneficiaries to be enrolled in a CMS-approved registry. A full list of CMS-approved registries, including the CMS-facilitated registry, is available at https://www.cms.gov/medicare/coverage/coverage-evidence-development/monoclonal-antibodies-directed-against-amyloid-treatment-alzheimers-disease-ad
  - There may be additional data inputs required at various time frames depending on the registry chosen
  - Some commercial plans may require a patient to be enrolled in a registry

Diagnosis information

- ☐ Diagnosis of mild cognitive impairment or mild dementia due to AD*
- ☐ Relevant clinical support, such as clinical notes, diagnostic results, etc

*Appropriate codes vary by patient, payer, and setting of care. Correct coding is the responsibility of the provider submitting the claim. Eisai Inc. does not make any representation or guarantee for reimbursement or coverage.

Checklist continues on following page

Please see Important Safety Information throughout and accompanying full Prescribing Information, including Boxed WARNING.

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Additional documentation that may support treatment decision			
Confirmation of amyloid beta (Aβ) pathology			
☐ CSF or PET imaging to verify presence of Aβ plaques. *(Note: Whether or not result is accepted as confirmatory will be payer dependent)*			
Baseline monitoring for amyloid-related imaging abnormalities (ARIA)			
☐ Recent baseline brain MRI within 12 months or less, prior to initiating treatment. Refer to payer policy			
Confirmation of cognitive impairment with a validated tool*			
☐ AD8 score	☐ MMSE score		
☐ CDR global score	☐ MoCA		
☐ Mini-Cog score	☐ SLUMS examination		
Confirmation of functional impairment with a validated tool*			
☐ FAQ score	☐ FAST	☐ CDR-SB	☐ ADL
Some plans may require the following			
☐ ApoE ε4 test results			
See glossary for acronym definitions			
Letter of medical necessity			
☐ Rationale for treatment: Summary statement of medical need and the reason(s) for the medication and/or service being requested, as well as documentation that all other causes of dementia have been ruled out			
☐ Summary of patient's diagnosis, including appropriate diagnosis codes (ICD-10), date of diagnosis, patient medical records, diagnostic test results and imaging results, current severity of the patient's condition including any comorbidities			
☐ Summary of patient's medical history, recent symptoms and conditions, and physician's opinion of patient prognosis or disease progression			

*Examples of cognitive or functional assessments are validated tests. This is not a comprehensive list. The health plan may require more than one validated test.
ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

Eisai cannot guarantee payment of any claim. Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient medical record.

IMPORTANT SAFETY INFORMATION (cont'd)

CONTRAINDICATION

Contraindicated in patients with serious hypersensitivity to lecanemab-irmb or to any of the excipients. Reactions have included angioedema and anaphylaxis.

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Reauthorization considerations	
Monitoring	
☐	MRI prior to 3rd, 5th, 7th, and 14th infusions
☐	Plans may have additional requirements for continued therapy (ie, repeat cognitive or functional assessments, etc.)
Maintenance therapy	
☐	After 18 months, patients can continue treatment once every 2 weeks, once every 4 weeks, or transition to LEQEMBI IQLIK™ once weekly, if appropriate.
☐	Submit new prior authorization, if required by plan

Contact your local Access and Reimbursement Manager for questions related to payer coverage or requirements

Glossary

AD8: Eight-item Informant Interview to Differentiate Aging and Dementia
ADL: Activities of Daily Living
ApoE ε4: apolipoprotein E ε4
CDR: Clinical Dementia Rating
CDR-SB: Clinical Dementia Rating-Sum of Boxes
CSF: cerebrospinal fluid
FAQ: Functional Activities Questionnaire
FAST: Functional Assessment Staging Test
MMSE: Mini-Mental State Exam
MoCA: Montreal Cognitive Assessment
MRI: magnetic resonance imaging
PET: positron emission tomography
SLUMS: Saint Louis University Mental Status

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS

AMYLOID-RELATED IMAGING ABNORMALITIES

Medications in this class, including LEQEMBI, can cause ARIA-E, which can be observed on MRI as brain edema or sulcal effusions, and ARIA-H, which includes microhemorrhage and superficial siderosis. ARIA can occur spontaneously in patients with AD, particularly in patients with MRI findings suggestive of cerebral amyloid angiopathy (CAA), such as pretreatment microhemorrhage or superficial siderosis. ARIA-H generally occurs with ARIA-E. Reported ARIA symptoms may include headache, confusion, visual changes, dizziness, nausea, and gait difficulty. Focal neurologic deficits may also occur. Symptoms usually resolve over time.

Incidence of ARIA

Symptomatic ARIA occurred in 3% and serious ARIA symptoms in 0.7% with LEQEMBI. Clinical ARIA symptoms resolved in 79% of patients during the period of observation. ARIA, including asymptomatic radiographic events, was observed: LEQEMBI, 21%; placebo, 9%. ARIA-E was observed: LEQEMBI, 13%; placebo, 2%. ARIA-H was observed: LEQEMBI, 17%; placebo, 9%. No increase in isolated ARIA-H was observed for LEQEMBI vs placebo.

Incidence of ICH

ICH >1 cm in diameter was reported in 0.7% with LEQEMBI vs 0.1% with placebo. Fatal events of ICH in patients taking LEQEMBI have been observed.

Risk Factors of ARIA and ICH

ApoE ε4 Carrier Status

Of the patients taking LEQEMBI, 16% were ApoE ε4 homozygotes, 53% were heterozygotes, and 31% were noncarriers. With LEQEMBI, ARIA was higher in ApoE ε4 homozygotes (LEQEMBI: 45%; placebo: 22%) than in heterozygotes (LEQEMBI: 19%; placebo: 9%) and noncarriers (LEQEMBI: 13%; placebo: 4%). Symptomatic ARIA-E occurred in 9% of ApoE ε4 homozygotes vs 2% of heterozygotes and 1% of noncarriers. Serious ARIA events occurred in 3% of ApoE ε4 homozygotes and in ~1% of heterozygotes and noncarriers. The recommendations on management of ARIA do not differ between ApoE ε4 carriers and noncarriers.

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IMPORTANT SAFETY INFORMATION (cont'd)
WARNINGS AND PRECAUTIONS (cont'd)
AMYLOID-RELATED IMAGING ABNORMALITIES (cont'd)

Risk Factors of ARIA and ICH (cont'd)

Radiographic Findings of CAA

Neuroimaging findings that may indicate CAA include evidence of prior ICH, cerebral microhemorrhage, and cortical superficial siderosis. CAA has an increased risk for ICH. The presence of an ApoE ε4 allele is also associated with CAA.

The baseline presence of at least 2 microhemorrhages or the presence of at least 1 area of superficial siderosis on MRI, which may be suggestive of CAA, have been identified as risk factors for ARIA. Patients were excluded from Clarity AD for the presence of >4 microhemorrhages and additional findings suggestive of CAA (prior cerebral hemorrhage >1 cm in greatest diameter, superficial siderosis, vasogenic edema) or other lesions (aneurysm, vascular malformation) that could potentially increase the risk of ICH.

Concomitant Antithrombotic or Thrombolytic Medication

In Clarity AD, baseline use of antithrombotic medication (aspirin, other antiplatelets, or anticoagulants) was allowed if the patient was on a stable dose. Most exposures were to aspirin. Antithrombotic medications did not increase the risk of ARIA with LEQEMBI. The incidence of ICH: 0.9% in patients taking LEQEMBI with a concomitant antithrombotic medication vs 0.6% with no antithrombotic and 2.5% in patients taking LEQEMBI with an anticoagulant alone or with antiplatelet medication such as aspirin vs none in patients receiving placebo.

Fatal cerebral hemorrhage has occurred in 1 patient taking an anti-amyloid monoclonal antibody in the setting of focal neurologic symptoms of ARIA and the use of a thrombolytic agent.

Additional caution should be exercised when considering the administration of antithrombotics or a thrombolytic agent (e.g., tissue plasminogen activator) to a patient already being treated with LEQEMBI. Because ARIA-E can cause focal neurologic deficits that can mimic an ischemic stroke, treating clinicians should consider whether such symptoms could be due to ARIA-E before giving thrombolytic therapy in a patient being treated with LEQEMBI.

Caution should be exercised when considering the use of LEQEMBI in patients with factors that indicate an increased risk for ICH and, in particular, patients who need to be on anticoagulant therapy or patients with findings on MRI that are suggestive of CAA.

Radiographic Severity With LEQEMBI

Most ARIA-E radiographic events occurred within the first 7 doses, although ARIA can occur at any time, and patients can have >1 episode. Maximum radiographic severity of ARIA-E with LEQEMBI was mild in 4%, moderate in 7%, and severe in 1% of patients. Resolution on MRI occurred in 52% of ARIA-E patients by 12 weeks, 81% by 17 weeks, and 100% overall after detection. Maximum radiographic severity of ARIA-H microhemorrhage with LEQEMBI was mild in 9%, moderate in 2%, and severe in 3% of patients; superficial siderosis was mild in 4%, moderate in 1%, and severe in 0.4% of patients. With LEQEMBI, the rate of severe radiographic ARIA-E was highest in ApoE ε4 homozygotes (5%) vs heterozygotes (0.4%) or noncarriers (0%). With LEQEMBI, the rate of severe radiographic ARIA-H was highest in ApoE ε4 homozygotes (13.5%) vs heterozygotes (2.1%) or noncarriers (1.1%).

Monitoring and Dose Management Guidelines

Baseline brain MRI and periodic monitoring with MRI are recommended. Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment. Depending on ARIA-E and ARIA-H clinical symptoms and radiographic severity, use clinical judgment when considering whether to continue dosing or to temporarily or permanently discontinue LEQEMBI. If a patient experiences ARIA symptoms, clinical evaluation should be performed, including MRI if indicated. If ARIA is observed on MRI, careful clinical evaluation should be performed prior to continuing treatment.

HYPERSENSITIVITY REACTIONS

Hypersensitivity reactions, including angioedema, bronchospasm, and anaphylaxis, have occurred with LEQEMBI. Promptly discontinue the infusion upon the first observation of any signs or symptoms consistent with a hypersensitivity reaction and initiate appropriate therapy.

INFUSION-RELATED REACTIONS (IRRs)

IRRs were observed—LEQEMBI: 26%; placebo: 7%—and most cases with LEQEMBI (75%) occurred with the first infusion. IRRs were mostly mild (69%) or moderate (28%). Symptoms included fever and flu-like symptoms (chills, generalized aches, feeling shaky, and joint pain), nausea, vomiting, hypotension, hypertension, and oxygen desaturation.

IRRs can occur during or after the completion of infusion. In the event of an IRR during the infusion, the infusion rate may be reduced or discontinued, and appropriate therapy initiated as clinically indicated. Consider prophylactic treatment prior to future infusions with antihistamines, acetaminophen, nonsteroidal anti-inflammatory drugs, or corticosteroids.

ADVERSE REACTIONS

- The most common adverse reactions reported in ≥5% with LEQEMBI infusion every 2 weeks and ≥2% higher than placebo were IRRs (LEQEMBI: 26%; placebo: 7%), ARIA-H (LEQEMBI: 14%; placebo: 8%), ARIA-E (LEQEMBI: 13%; placebo: 2%), headache (LEQEMBI: 11%; placebo: 8%), superficial siderosis of central nervous system (LEQEMBI: 6%; placebo: 3%), rash (LEQEMBI: 6%; placebo: 4%), and nausea/vomiting (LEQEMBI: 6%; placebo: 4%)
- Safety profile of LEQEMBI IQLIK for maintenance treatment was similar to LEQEMBI infusion. Patients who received LEQEMBI IQLIK experienced localized and systemic (less frequent) injection-related reactions (mild to moderate in severity)

LEQEMBI (lecanemab-irmb) is available:

- Intravenous infusion: 100 mg/mL
- Subcutaneous injection: 200 mg/mL

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