Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

AMYLOID-TARGETED MONOCLONAL ANTIBODIES (MABs) PRIOR AUTHORIZATION FORM

(form effective 7/6/2026)

Prior authorization guidelines for **Amyloid-Targeted Monoclonal Antibodies (MABs)** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:
Total quantity per fill:	Duration:
Directions:	Weight: _____ kg
Diagnosis:	Dx code (*required*):
SPECIALTY PHARMACY DRUG PROGRAM: Amyloid-Targeted MABs are included in the DHS Specialty Pharmacy Drug Program and are available from DHS's specialty pharmacy. Refer to https://www.pa.gov/agencies/dhs/resources/pharmacy-services/specialty-pharmacy-program for more information about the Specialty Pharmacy Drug Program.	**DHS specialty pharmacy:** Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com
Is the requested drug prescribed by a dementia specialist (e.g., neurologist, psychiatrist, geriatrician)? ☐Yes ☐No	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

☐Has at least TWO of the following:
- ☐Mini-Mental State Examination (MMSE) score of 18 to 23
- ☐Montreal Cognitive Assessment (MoCA) score of 18 to 25
- ☐Global Clinical Dementia Rating Scale (CDR) score of 0.5 or 1

☐Will be monitored and assessed by the prescribing dementia specialist at least every 3 months while taking the requested drug

☐Has baseline MRI results as recommended in the FDA-approved package labeling

☐ Has ONE of the following confirming beta-amyloid pathology:
- ☐ Positive amyloid positron emission tomography scan
- ☐ Positive cerebrospinal fluid biomarker testing (Aβ42/40 ratio or total tau/Aβ42 ratio)
- ☐ Positive FDA-cleared plasma biomarker assay validated for the identification of brain amyloid pathology (e.g., p-tau217 ratio-based assays)

☐ Does NOT have any of the following:
- ☐ A contraindication to MRI scanning (e.g., cardiac pacemaker/defibrillator or ferromagnetic metal implants)
- ☐ A medical or neurological condition (other than Alzheimer's disease) that might be a significant contributing cause of the beneficiary's cognitive impairment
- ☐ A history of stroke, TIA, or seizures in the past year
- ☐ A bleeding disorder that is not under adequate control
- ☐ Any significant pathological findings on brain MRI at screening that indicate an increased risk for amyloid-related imaging abnormalities or intracerebral hemorrhage

RENEWAL requests

☐ Is experiencing medical benefit from and tolerability of the requested drug

☐ Has repeat testing and documented results of at least TWO of the following:
- ☐ Mini-Mental State Examination (MMSE)
- ☐ Montreal Cognitive Assessment (MoCA)
- ☐ Global Clinical Dementia Rating Scale (CDR)

☐ Was monitored and assessed by the prescribing dementia specialist at least every 3 months while taking the requested drug

☐ Will continue to be monitored and assessed by the prescribing dementia specialist at least every 3 months while taking the requested drug

☐ Does NOT have any of the following:
- ☐ A contraindication to MRI scanning (e.g., cardiac pacemaker/defibrillator or ferromagnetic metal implants)
- ☐ A medical or neurological condition (other than Alzheimer's disease) that might be a significant contributing cause of the beneficiary's cognitive impairment
- ☐ A history of stroke, TIA, or seizures in the past year
- ☐ A bleeding disorder that is not under adequate control

☐ Is continuing treatment with the requested drug based on recent MRI results as recommended in the FDA-approved package labeling

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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