COVERAGE AUTHORIZATION REQUEST AND APPEALS GUIDE

Preparing a Coverage Authorization Appeals Letter

kisunla™ (donanemab-azbt) injection for IV infusion 350 mg/20 mL

The following information is presented as a guide for informational purposes only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Eli Lilly and Company, with the use of the information contained herein, does not guarantee success in obtaining insurance payments. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. Providers are encouraged to contact third-party payers for specific information on their coverage policies. For more information, please call Lilly Support Services™ at 1-800-Lilly-Rx (1-800-545-5979).

If the patient's initial claim or Coverage Authorization Request Letter is denied by the patient's health plan, the payer may require a Coverage Authorization Appeals Letter. Depending on the plan, there may be varying levels of appeals. If you are uncertain about a plan's appeal levels or specific procedures, always refer to the plan's appeal guidelines.

This resource, **Preparing a Coverage Authorization Appeals Letter**, provides information to healthcare providers (HCPs) when appealing a coverage authorization decision for a patient's plan. Included on the following page is a list of considerations that can be followed when creating a Coverage Authorization Appeals Letter. In addition, 2 sample letters are attached to this document and feature information that many plans require to process a coverage authorization appeal. Follow the patient's plan requirements when requesting Kisunla, otherwise treatment may be delayed.

A **Coverage Authorization Appeals Letter** originates from the patient and the prescribing HCP.* It should be submitted with 2 additional items: the patient's medical records and a Letter of Medical Necessity. Also see **Composing a Letter of Medical Necessity** for more information.

*For Medicare beneficiaries, specific requirements must be met for the HCP to be considered a legal representative of the patient in an appeal. For additional information, please visit https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

INDICATION

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

SELECT IMPORTANT SAFETY INFORMATION

WARNING: AMYLOID-RELATED IMAGING ABNORMALITIES

Monoclonal antibodies directed against aggregated forms of beta amyloid, including Kisunla, can cause amyloid-related imaging abnormalities (ARIA), characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H). ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events rarely can occur. Serious intracerebral hemorrhages >1 cm, some of which have been fatal, have been observed in patients treated with this class of medications. 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 Kisunla.

ApoE ε4 Homozygotes: Patients who are apolipoprotein E ε4 (ApoE ε4) homozygotes treated with this class of medications, including Kisunla, 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.

Consider the benefit for the treatment of Alzheimer's disease and risk of ARIA when deciding to treat with Kisunla.

Please see Important Safety Information, including Boxed Warning regarding ARIA, on pages 5-7, and click for full Prescribing Information and Medication Guide for Kisunla.

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Preparing a Coverage Authorization Appeals Letter

Coverage Authorization Requests: Guidance and Recommendations

1. Include the patient's full name, date of birth, and plan identification number.
2. Add the prescribing HCP's National Provider (NPI) number and specialty.
3. Disclose that you are familiar with the plan's policy. Clearly document the basis for the plan's denial within the letter, along with case identification number from the initial denial letter.
4. Provide a copy of the patient's records with the following details: patient's history, diagnosis, and condition. Relevant clinical information may include, but is not limited to:
   - Diagnosis of Alzheimer's disease (mild cognitive impairment (MCI) or mild dementia stage of disease), as well as the date of diagnosis.
     - Consider including the patient's ICD-10 diagnosis code(s) as appropriate.
   - Result and Date of Recent Baseline Magnetic Resonance Imaging (MRI) prior to initiating treatment
   - Confirmation of Amyloid Pathology, including the type of test and date it was performed, for example:
     - Amyloid Positron Emission Tomography (PET) Scan
     - Cerebrospinal Fluid (CSF)
     - Other Amyloid Test
   - Cognitive Assessments with a validated tool (may require more than one), including date, type, and score of test. For example:
     - Clinical Dementia Rating (CDR) Scale
     - Mini-Mental State Exam (MMSE) score
     - Montreal Cognitive Assessment (MoCA)
     - Other Cognitive Test and associated score
   - Functional Assessments with a validated tool (may require more than one), including date, type, and score of test. For example:
     - The Functional Activities Questionnaire (FAQ) score
     - Other Functional Test and associated score
   - Whether the patient has any history of Amyloid-Related Imaging Abnormalities (ARIA), either ARIA-E or ARIA-H. Please note if there is evidence of ARIA and the date of the MRI, if any.
5. Note the severity of the patient's condition. Kisunla is indicated for the treatment of Alzheimer's disease (AD). Treatment with Kisunla should be initiated in patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in the clinical trials.
6. Document prior treatment, duration of each, and the rationale for discontinuation.
7. Explain why the plan's preferred formulary agents and/or denial rationale(s) are not appropriate for this patient.
8. Provide the clinical rationale for this treatment; this information may be found in the Kisunla Prescribing Information and/or clinical peer-reviewed literature.
9. Summarize your recommendation at the end of the letter.
10. Include a Letter of Medical Necessity.

Preparing a Coverage Authorization Appeals Letter

HCPs can utilize this format for patients who are **NOT** currently receiving treatment with Kisunla™ (donanemab-azbt).

[Date]
[Prior Authorization/Appeals Department]
[Name of health plan]
[Mailing address]

Re: [Patient's name]
[Plan identification number]
[Date of birth]

To whom it may concern:

We have reviewed and recognize your guidelines for the responsible management of medications within this class. We are requesting that you reassess your recent denial of Kisunla (donanemab-azbt) coverage. We understand that the reason for your denial is **[copy reason verbatim from the plan's denial letter]**. However, we believe that Kisunla 700 mg IV every 4 weeks for 3 infusions, then 1400 mg IV every 4 weeks thereafter is the appropriate treatment for the patient. In support of our recommendation for Kisunla treatment, we have provided an overview of the patient's relevant clinical history below.

[Patient's history, diagnosis, condition, and symptoms*:
Patient must have a diagnosis for an indication of Kisunla. Kisunla is indicated for the treatment of Alzheimer's disease (AD) in patients with mild cognitive impairment (MCI) or mild dementia stage of disease. Please reference the guidance on page 2 and include any co-morbidities, confirmation of amyloid positivity, concomitant medications, and all relevant information pertaining to the patient's diagnosis, condition, and symptoms.]

Past Treatments†	Start/Stop Dates	Reason(s) for Discontinuation

[Please detail all that apply and add additional lines as needed.]

[Provide clinical rationale for this treatment; this information may be found in the full Prescribing Information for Kisunla and/or clinical peer-reviewed literature.]

[Insert your recommendation summary here, including your professional opinion of the patient's likely prognosis or disease progression without treatment with Kisunla.]

Please feel free to contact me, **[HCP's name]**, at **[office phone number]** for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

[Physician's name and signature]
[Physician's medical specialty]
[Physician's NPI #]
[Physician's practice name]
[Phone #]
[Fax #]

[Patient's name and signature]

Encl: Medical records
Clinical trial information
Letter of Medical Necessity

When appealing a plan's step edit therapy requirement, consider providing statements indicating why these requirements are inappropriate for the patient, including contraindications and examples of previous therapy trials/failures due to lack of response or drug intolerance.

*Include patient's medical records and supporting documentation.
†Identify drug name, strength, dosage form, and therapeutic outcome.

Preparing a Coverage Authorization Appeals Letter

HCPs can utilize this format for patients who **HAVE** been treated with Kisunla™ (donanemab-azbt) and may have experienced a treatment interruption.

[Date]
[Prior authorization/appeals department]
[Name of health plan]
[Mailing address]

Re: **[Patient's name]**
[Plan identification number]
[Date of birth]

To whom it may concern:

We have reviewed and recognize your guidelines for the responsible management of medications within this class. We are requesting that you reassess your recent denial of Kisunla (donanemab-azbt) coverage. We understand that the reason for your denial is **[copy reason verbatim from the plan's denial letter]**. However, we believe that Kisunla 700 mg IV every 4 weeks for 3 infusions, then 1400 mg IV every 4 weeks thereafter is the appropriate treatment for the patient. In support of our recommendation for Kisunla treatment, we have provided an overview of the patient's relevant clinical history below.

[In this section, describe the clinical presentation of the disease at the time when the patient was first prescribed Kisunla. In addition, include the results of any safety monitoring MRIs. It may be necessary to review past medical records to gather this information].

[Patient's history, diagnosis, condition, and symptoms*:
Patient must have a diagnosis for an indication of Kisunla. Kisunla is indicated for the treatment of Alzheimer's disease (AD) in patients with mild cognitive impairment (MCI) or mild dementia stage of disease. Please reference the guidance on page 2 and include any co-morbidities, confirmation of amyloid positivity, concomitant medications, and all relevant information pertaining to the patient's diagnosis, condition, and symptoms.]

Past Treatments†	Start/Stop Dates	Reason(s) for Discontinuation

[Please detail all that apply and add additional lines as needed.]

[Provide clinical rationale for this treatment; this information may be found in the Kisunla Prescribing Information and/or clinical peer-reviewed literature.]

[Insert your recommendation summary here, including your professional opinion of the patient's likely prognosis or disease progression without treatment with Kisunla.]

Please feel free to contact me, **[HCP's name]**, at **[office phone number]** for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,
[Physician's name and signature]
[Physician's medical specialty]
[Physician's NPI #]
[Physician's practice name]
[Phone #]
[Fax #]

[Patient's name and signature]

Encl: Medical Records
Clinical trial information
Letter of Medical Necessity

When appealing a plan's step edit therapy requirement, consider providing statements indicating why these requirements are inappropriate for the patient, including contraindications and examples of previous therapy trials/failures due to lack of response or drug intolerance.

*Include patient's medical records and supporting documentation.
†Identify drug name, strength, dosage form, and therapeutic outcome.

IMPORTANT SAFETY INFORMATION FOR Kisunla™ (donanemab-azbt)

WARNING: AMYLOID-RELATED IMAGING ABNORMALITIES

Monoclonal antibodies directed against aggregated forms of beta amyloid, including Kisunla, can cause amyloid-related imaging abnormalities (ARIA), characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H). ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events rarely can occur. Serious intracerebral hemorrhages >1 cm, some of which have been fatal, have been observed in patients treated with this class of medications. 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 Kisunla.

ApoE ε4 Homozygotes: Patients who are apolipoprotein E ε4 (ApoE ε4) homozygotes (approximately 15% of Alzheimer's disease patients) treated with this class of medications, including Kisunla, 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 Kisunla; however, it cannot be determined if they are ApoE ε4 homozygotes and at higher risk for ARIA.

Consider the benefit of Kisunla for the treatment of Alzheimer's disease and potential risk of serious adverse events associated with ARIA when deciding to initiate treatment with Kisunla.

Kisunla is **contraindicated** in patients with known serious hypersensitivity to donanemab-azbt or to any of the excipients. Reactions have included anaphylaxis.

Amyloid-Related Imaging Abnormalities (ARIA)

Kisunla can cause ARIA-E, which can be observed on magnetic resonance imaging (MRI) as brain edema or sulcal effusions, and ARIA-H, which includes microhemorrhage and superficial siderosis. ARIA can occur spontaneously in patients with Alzheimer's disease (AD), particularly in patients with MRI findings suggestive of cerebral amyloid angiopathy, such as pretreatment microhemorrhage or superficial siderosis. ARIA-H generally occurs with ARIA-E.

ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events, including seizure and status epilepticus, rarely can occur. When present, reported symptoms associated with ARIA may include, but are not limited to, headache, confusion, visual changes, dizziness, nausea, and gait difficulty. Focal neurologic deficits may also occur. Symptoms associated with ARIA usually resolve over time. In addition to ARIA, intracerebral hemorrhages (ICH) >1 cm in diameter have occurred in patients treated with Kisunla.

Incidence of ARIA

Symptomatic ARIA occurred in 6% (52/853) of patients treated with Kisunla. Clinical symptoms associated with ARIA resolved in approximately 85% (44/52) of patients.

Including asymptomatic radiographic events, ARIA was observed with Kisunla: 36% (307/853); placebo: 14% (122/874). ARIA-E was observed with Kisunla: 24% (201/853); placebo: 2% (17/874). ARIA-H was observed with Kisunla: 31% (263/853); placebo: 13% (111/874). There was no increase in isolated ARIA-H for Kisunla vs placebo.

Incidence of ICH

ICH >1 cm in diameter was reported in 0.5% (4/853) of patients after treatment with Kisunla vs 0.2% (2/874) on placebo. Fatal events of ICH have been observed.

Please see Important Safety Information, including Boxed Warning regarding ARIA, on pages 5-7, and click for full Prescribing Information and Medication Guide for Kisunla.

IMPORTANT SAFETY INFORMATION FOR Kisunla™ (donanemab-azbt) (continued)

Risk Factors for ARIA and ICH

ApoE ε4 Carrier Status

The risk of ARIA, including symptomatic and serious ARIA, is increased in apolipoprotein E ε4 (ApoE ε4) homozygotes. 17% (143/850) of patients in the Kisunla arm were ApoE ε4 homozygotes, 53% (452/850) were heterozygotes, and 30% (255/850) were noncarriers. The incidence of ARIA was higher in ApoE ε4 homozygotes (Kisunla: 55%; placebo: 22%) than in heterozygotes (Kisunla: 36%; placebo: 13%) and noncarriers (Kisunla: 25%; placebo: 12%). Among patients treated with Kisunla, symptomatic ARIA-E occurred in 8% of ApoE ε4 homozygotes compared with 7% of heterozygotes and 4% of noncarriers. Serious events of ARIA occurred in 3% of ApoE ε4 homozygotes, 2% of heterozygotes, and 1% of noncarriers.

The recommendations for management of ARIA do not differ between ApoE ε4 carriers and noncarriers. Testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA. An FDA-authorized test for detection of ApoE ε4 alleles is not currently available. Currently available tests may vary in accuracy and design.

Radiographic Findings of Cerebral Amyloid Angiopathy (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, were identified as risk factors for ARIA. Patients were excluded from enrollment in Study 1 for findings on neuroimaging of prior ICH >1 cm in diameter, >4 microhemorrhages, >1 area of superficial siderosis, severe white matter disease, and vasogenic edema.

Concomitant Antithrombotic or Thrombolytic Medication

In Study 1, baseline use of antithrombotic medication (aspirin, other antiplatelets, or anticoagulants) was allowed. The majority of exposures to antithrombotic medications were to aspirin. The incidence of ARIA-H was 30% (106/349) in patients taking Kisunla with a concomitant antithrombotic medication within 30 days vs 29% (148/504) in patients who did not receive an antithrombotic within 30 days of an ARIA-H event. The incidence of ICH >1 cm in diameter was 0.6% (2/349) in patients taking Kisunla with a concomitant antithrombotic medication vs 0.4% (2/504) in those who did not receive an antithrombotic. The number of events and the limited exposure to non-aspirin antithrombotic medications limit definitive conclusions about the risk of ARIA or ICH in patients taking antithrombotic medications.

One fatal ICH occurred in a patient taking Kisunla 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 (eg, tissue plasminogen activator) to a patient already being treated with Kisunla.

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 Kisunla. Advise patients to carry information that they are being treated with Kisunla.

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

IMPORTANT SAFETY INFORMATION FOR Kisunla™ (donanemab-azbt) (continued)

Radiographic Severity

The majority of ARIA-E radiographic events occurred early in treatment (within the first 24 weeks), although ARIA can occur at any time and patients can have more than one episode. The maximum radiographic severity of ARIA-E in patients treated with Kisunla was mild in 7% (59/853), moderate in 15% (128/853), and severe in 2% (14/853). Resolution on MRI after the first ARIA-E event occurred in 63% of patients treated with Kisunla by 12 weeks, 80% by 20 weeks, and 83% overall after detection. The maximum radiographic severity of ARIA-H microhemorrhage in patients treated with Kisunla was mild in 17% (143/853), moderate in 4% (34/853), and severe in 5% (40/853). The maximum radiographic severity of ARIA-H superficial siderosis in patients treated with Kisunla was mild in 6% (47/853), moderate in 4% (32/853), and severe in 5% (46/853). Among patients treated with Kisunla, the rate of severe radiographic ARIA-E was highest in ApoE ε4 homozygotes 3% (4/143) vs heterozygotes 2% (9/452) or noncarriers 0.4% (1/255). The rate of severe radiographic ARIA-H was highest in ApoE ε4 homozygotes 22% (31/143) vs heterozygotes 8% (38/452) or noncarriers 4% (9/255).

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 24 weeks of treatment with Kisunla. If a patient experiences symptoms suggestive of ARIA, 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.

Recommendations for dosing in patients with ARIA-E and ARIA-H depend on clinical symptoms and radiographic severity. Depending on ARIA severity, use clinical judgment in considering whether to continue dosing, interrupt treatment, or permanently discontinue Kisunla. See Prescribing Information for additional dosing considerations.

There is limited experience in patients who continued dosing through asymptomatic but radiographically mild to moderate ARIA-E. There are limited data for dosing patients who experienced recurrent episodes of ARIA-E.

Hypersensitivity Reactions

Hypersensitivity reactions, including anaphylaxis and angioedema, have occurred in patients who were treated with Kisunla. 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 (IRR)

IRRs were observed with Kisunla: 9% (74/853); placebo: 0.5% (4/874); the majority (70%, 52/74) occurred within the first 4 infusions. IRRs typically occur during infusion or within 30 minutes post-infusion. IRRs were mostly mild (57%) or moderate (39%) in severity. IRRs resulted in discontinuations in 4% (31/853). Signs and symptoms of IRRs include chills, erythema, nausea/vomiting, difficulty breathing/dyspnea, sweating, elevated blood pressure, headache, chest pain, and low blood pressure.

In the event of an IRR, the infusion rate may be reduced, or the infusion may be discontinued, and appropriate therapy initiated as clinically indicated. Pretreatment with antihistamines, acetaminophen, or corticosteroids prior to subsequent dosing may be considered.

Adverse Reactions: The most common adverse reactions reported in ≥5% of patients treated with Kisunla (n=853) and ≥2% higher than placebo (n=874): ARIA-H microhemorrhage (25% vs 11%), ARIA-E (24% vs 2%), ARIA-H superficial siderosis (15% vs 3%), headache (13% vs 10%), IRRs (9% vs 0.5%).

Please click for full Prescribing Information, including Boxed Warning regarding ARIA, and Medication Guide.

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kisunla™ (donanemab-azbt) injection for IV infusion 350 mg/20 mL