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PHARMACY / MEDICAL POLICY – 5.01.626

Amyloid Antibodies for the Treatment of Alzheimer's Disease

Effective Date:	Sep. 1, 2026	RELATED MEDICAL POLICIES: N/A
Last Revised:	Aug. 11, 2026	
Replaces:	N/A	

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING | EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Alzheimer's disease (AD) is a progressive disease that leads to loss in memory, language, and thinking and mostly affects adults over 65 years of age. The loss of memory is the most common initial symptom but other symptoms in people with mild AD can also include changes in behavior or mood. One common finding in people with AD is the development of plaques (amyloid beta plaques) between brain cells and tangles of twisted fiber (tau protein) within the brain cells. These plaques and tangles in the brain of people with AD is often more extensive than people without AD and research regarding the role of these plaques and tangles is ongoing.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Drug	Medical Necessity

Kisunla (donanemab-azbt) IV	**Kisunla (donanemab-azbt) may be considered medically necessary for the treatment of adults with Alzheimer's disease when ALL the following are met:**
	• The individual is aged 18 years or older
	AND
	• Diagnosed with Alzheimer's disease
	AND
	• Cognitive test results indicate mild cognitive impairment OR mild Alzheimer's disease dementia as documented by 1 of the following:
	  ○ Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
	  ○ CDR Memory Box score of at least 0.5
	  ○ Mini-Mental Status Examination (MMSE) score of at least 22
	  ○ Montreal Cognitive Assessment (MoCA) score of at least 17
	AND
	• Has documented presence of beta-amyloid protein deposition as evidenced by 1 of the following:
	  ○ Positive amyloid positron emission tomography (PET) scan
	  ○ Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation in the brain
	AND
	• Chart notes document testing for ApoE ε4 status and that potential risks have been discussed including the risk of amyloid-related imaging abnormalities with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H)
	AND
	• A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment
	AND
	• Does not have cognitive impairment due to other medical conditions (e.g., dementia with Lewy bodies, frontotemporal dementia, vascular dementia, vitamin B12 deficiency, encephalopathy, pseudodementia due to mood disorder, or untreated thyroid disease)
	AND

Drug	Medical Necessity
	• Kisunla (donanemab-azbt) will not be used in combination with other monoclonal antibodies for the treatment of Alzheimer's disease such as Leqembi (lecanemab-irmb) or Leqembi Iqlik (lecanemab-irmb) **AND** • Kisunla (donanemab-azbt) is prescribed by or in consultation with a specialist in dementia such as a neurologist, geriatric psychiatrist, neuropsychiatrist, or geriatrician **AND** • The maintenance dose is limited to 1,400 mg every 4 weeks

Leqembi (lecanemab-irmb) IV	**Leqembi (lecanemab-irmb) may be considered medically necessary for the treatment of adults with Alzheimer's disease when ALL the following are met:**
	• The individual is aged 18 years or older
	AND
	• Diagnosed with Alzheimer's disease
	AND
	• Cognitive test results indicate mild cognitive impairment OR mild Alzheimer's disease dementia as documented by 1 of the following:
	  ○ Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
	  ○ CDR Memory Box score of at least 0.5
	  ○ Mini-Mental Status Examination (MMSE) score of at least 22
	  ○ Montreal Cognitive Assessment (MoCA) score of at least 17
	AND
	• Has documented presence of beta-amyloid protein deposition as evidenced by 1 of the following:
	  ○ Positive amyloid positron emission tomography (PET) scan
	  ○ Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation in the brain
	AND
	• Chart notes document testing for ApoE ε4 status and that potential risks have been discussed including the risk of amyloid related imaging abnormalities with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H)
	AND

Drug	Medical Necessity

	• A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment
	AND
	• Does not have cognitive impairment due to other medical conditions (e.g., dementia with Lewy bodies, frontotemporal dementia, vascular dementia, vitamin B12 deficiency, encephalopathy, pseudodementia due to mood disorder, or untreated thyroid disease)
	AND
	• Leqembi (lecanemab-irmb) will not be used in combination with other monoclonal antibodies for the treatment of Alzheimer's disease such as Kisunla (donanemab-azbt)
	AND
	• Leqembi (lecanemab-irmb) is prescribed by or in consultation with a specialist in dementia such as a neurologist, geriatric psychiatrist, neuropsychiatrist, or geriatrician
	AND
	• The dose is limited to:
	  ○ 10 mg/kg once every two weeks for 18 months
	  ○ After 18 months, 10 mg/kg once every 2 weeks or 10 mg/kg once every 4 weeks

Leqembi Iqlik (lecanemab-irmb) SC	**Leqembi Iqlik (lecanemab-irmb) may be considered medically necessary for the treatment of adults with Alzheimer's disease when ALL the following are met:**
	• The individual is aged 18 years or older
	AND
	• Diagnosed with Alzheimer's disease
	AND
	• Cognitive test results indicate mild cognitive impairment OR mild Alzheimer's disease dementia as documented by 1 of the following:
	  ○ Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
	  ○ CDR Memory Box score of at least 0.5
	  ○ Mini-Mental Status Examination (MMSE) score of at least 22
	  ○ Montreal Cognitive Assessment (MoCA) score of at least 17
	AND

Drug	Medical Necessity

	• Has documented presence of beta-amyloid protein deposition as evidenced by 1 of the following:
	  ○ Positive amyloid positron emission tomography (PET) scan
	  ○ Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation in the brain
	AND
	• Chart notes document testing for ApoE ε4 status and that potential risks have been discussed including the risk of amyloid related imaging abnormalities with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H)
	AND
	• A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment
	AND
	• Does not have cognitive impairment due to other medical conditions (e.g., dementia with Lewy bodies, frontotemporal dementia, vascular dementia, vitamin B12 deficiency, encephalopathy, pseudodementia due to mood disorder, or untreated thyroid disease)
	AND
	• Leqembi Iqlik (lecanemab-irmb) will not be used in combination with other monoclonal antibodies for the treatment of Alzheimer's disease such as Kisunla (donanemab-azbt)
	AND
	• Leqembi Iqlik (lecanemab-irmb) is prescribed by or in consultation with a specialist in dementia such as a neurologist, geriatric psychiatrist, neuropsychiatrist, or geriatrician
	AND
	• The dose is limited to 500 mg once every week
	AND
	• The quantity is limited to:
	  ○ 250 mg/1.25 ml autoinjector: 8 autoinjectors per 28 days
	  ○ 360 mg/1.5 ml autoinjector: 4 autoinjectors per 28 days

Drug	Investigational
• **Kisunla (donanemab-azbt)** • **Leqembi (lecanemab-irmb)** • **Leqembi Iqlik (lecanemab-irmb)**	**All other uses of Kisunla (donanemab-azbt), Leqembi (lecanemab-irmb), and Leqembi Iqlik (lecanemab-irmb) for conditions not outlined in this policy are considered investigational.** **Kisunla (donanemab-azbt), Leqembi (lecanemab-irmb), and Leqembi Iqlik (lecanemab-irmb) are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.**

Length of Approval	
Approval	**Criteria**
Initial authorization	**Kisunla (donanemab-azbt), Leqembi (lecanemab-irmb), and Leqembi Iqlik (lecanemab-irmb) may be approved for up to 12 months.**
Re-authorization criteria	**Kisunla (donanemab-azbt), Leqembi (lecanemab-irmb), and Leqembi Iqlik (lecanemab-irmb) may be approved up to 12 months when ALL the following are met:** • The drug-specific policy coverage criteria are met • Medical records demonstrate that the individual continues to show a positive clinical response to therapy • A brain magnetic resonance imaging (MRI) is completed to check for radiographically observed amyloid related imaging abnormalities (ARIA) when warranted

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Office visit notes that contain the diagnosis, relevant history, physical evaluation, and medication history

Coding

Code	Description
HCPCS	
J0174	Lecanemab-irmb (Leqembi), for intravenous injection, 1 mg
J0175	Injection, donanemab-azbt (Kisunla), 2 mg

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Evidence Review

Benefit Application

Medical Benefit

Kisunla (donanemab-azbt) and Leqembi (lecanemab-irmb) are managed through the medical benefit.

Pharmacy/Medical Benefit

Leqembi Iqlik (lecanemab-irmb) is managed through both the pharmacy benefit and medical benefit.

Description

Alzheimer's disease is a neurodegenerative disorder leading to progressive, irreversible destruction of neurons and loss of cognitive function and memory. Over time, individuals progress to severe dementia, loss of independence, and death. Extracellular deposits of amyloid beta (A-β), referred to as amyloid plaques, are considered a hallmark of the disease. Beta-amyloid monomers lead to the formation of beta oligomers and fibrils and are deposited as plaques and then interact with tau fibrils, leading to formation of neurofibrillatory tangles. These pathophysiological changes and clinical manifestations of Alzheimer's disease are progressive and occur along a continuum, and accumulation of A-β may begin 20 years or more before

symptoms arise. Kisunla (donanemab-azbt) and Leqembi (lecanemab-irmb) are amyloid beta-directed antibodies that are approved for the treatment of Alzheimer's disease.

Background

Alzheimer's Disease

Alzheimer's disease is a fatal neurodegenerative disease that causes progressive loss in memory, language, and thinking, with the eventual loss of ability to perform social and functional activities in daily life. Survival after a diagnosis of dementia due to Alzheimer's disease generally ranges between 4 and 8 years; however, life expectancy can be influenced by other factors, such as comorbid medical conditions. It is estimated that 6.2 million Americans aged 65 and older are currently living with Alzheimer's disease dementia, and the number is projected to reach over 12 million by 2050.

Pathophysiology

The pathologic hallmarks of Alzheimer's disease are extracellular deposits of beta-amyloid (A-β), referred to as amyloid plaques, and intracellular aggregates of hyperphosphorylated tau in the form of neurofibrillary tangles. There are different forms of amyloid such as plaques, oligomers, and monomers, and the roles of these different forms and how specifically they are pathophysiologically associated with Alzheimer's disease is not well understood. Generally referred to as "amyloid hypothesis", it is believed that aggregation of A-β oligomers in the brain leads to amyloid plaques and is thought to be the primary driver of the disease process. Amyloid aggregation is thought to precede accumulation of tau pathology and neurodegeneration. These changes in the brain result in widespread neurodegeneration and cell death, and ultimately cause the clinical signs and symptoms of dementia.

Salient known risk factors for Alzheimer's disease are older age, genetics, and family history. Of these, increasing age has the largest known impact on the risk of developing Alzheimer's disease. While several genes have been found to increase the risk of Alzheimer's disease, the ε4 allele of the apolipoprotein E (ApoE) gene is the strongest known genetic risk factor. Having 1 copy of the gene is associated with a 2- to 3-fold increase in developing Alzheimer's disease while 2 copies of the gene may increase risk of Alzheimer's disease by as much as 15 times. Approximately two-thirds of pathology-confirmed Alzheimer's disease cases are ε4 positive (homozygous or heterozygous), compared with about 15% to 20% of the general population.

Autosomal dominant genetic mutations are estimated to account for less than 1% of Alzheimer's disease cases.

The pathophysiological changes and clinical manifestations of Alzheimer's disease are progressive and occur along a continuum, and accumulation of A-β may begin 20 years or more before symptoms arise. National Institute on Aging-Alzheimer's Association (NIA-AA) have created a "numeric clinical staging scheme" (Table 1) that avoids traditional syndromal labels and is applicable for only those in the Alzheimer's continuum. This staging scheme reflects the sequential evolution of Alzheimer's disease from an initial stage characterized by the appearance of abnormal Alzheimer's disease biomarkers in asymptomatic individuals. As biomarker abnormalities progress, the earliest subtle symptoms become detectable. Further progression of biomarker abnormalities is accompanied by progressive worsening of cognitive symptoms, culminating in dementia. This numeric cognitive staging scheme is not designed to be used in a clinical setting but to be used for interventional trials. This numeric staging scheme is very similar to the categorical system for staging Alzheimer's disease outlined in the Food and Drug Administration (FDA) guidance for industry pertaining to developing drugs for treatment of early Alzheimer's disease.

Many tests are available to detect the underlying core pathology such use of certain biomarkers in the cerebrospinal fluid (CSF) (e.g., decreased A-β and increased CSF tau protein levels) and on imaging (e.g., amyloid on positron emission tomography [PET] scans). Approved amyloid PET tracers in the US include [18F]-florbetapir, [18F]-flutemetamol and [18F]-florbetaben. In addition, there are several CSF tests for A-β confirmation that are currently in development in the US. CSF tests and amyloid PET tracers are routinely used in the enrollment of participants in contemporary Alzheimer's disease studies.

Current Treatment

Current treatment goals for individuals with Alzheimer's disease are often directed to maintain quality of life, treat cognitive symptoms, and manage behavioral and psychological symptoms of dementia. Treatment remains largely supportive, including creation and implementation of individualized dementia care plans, caregiver education and support, care navigation, care coordination, and referral to community-based organizations for services (e.g., adult day care, caregiver training, etc.). Non-pharmacologic treatments include physical activity as well as behavioral strategies to ameliorate neuropsychiatric symptoms (e.g., agitation, delusions, disinhibition), and problem behaviors (e.g., resistance to care, hoarding, obsessive-compulsive behaviors). Currently FDA-approved drugs for Alzheimer's include cholinesterase inhibitors donepezil, rivastigmine, and galantamine, and the N-methyl-D-aspartate antagonist memantine.

Cholinesterase inhibitors are indicated in mild, moderate, and severe AD, while memantine is approved for moderate-to-severe AD. These drugs, either alone or in combination, focus on managing cognitive and functional symptoms of the disease and have not been shown to alter disease trajectory. The evidence for efficacy is limited and associated with significant side effects.

Table 1. National Institute on Aging-Alzheimer's Association Numerical Clinical Staging for Individuals in the Alzheimer's Continuum[a]

Stage	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Severity	**Pre-clinical**	**Pre-clinical**	**MCI due to Alzheimer's disease**	**Mild Dementia**	**Moderate Dementia**	**Severe Dementia**
Clinical Features	• Performance within expected range on objective cognitive tests. • No evidence of recent cognitive decline or new neurobehavioral symptoms.	• Normal performance within expected range on objective cognitive tests. • Transitional cognitive decline (change from individual baseline within past 1 to 3 years, and persistent for at least 6 months). • Mild neurobehavioral changes may coexist or may be the primary complaint rather than cognitive. • No functional impact on daily life activities	• Performance in the impaired/ abnormal range on objective cognitive tests. • Evidence of decline from baseline. • Performs daily life activities independently, but cognitive difficulty may result in detectable but mild functional impact on the more complex activities of daily life.	• Substantial progressive cognitive impairment affecting several domains, and/or neurobehavioral disturbance. • Clearly evident functional impact on daily life, affecting mainly instrumental activities. • No longer fully independent /requires occasional assistance with daily life activities.	• Progressive cognitive impairment or neurobehavioral changes. • Extensive functional impact on daily life with impairment in basic activities. • No longer independent and requires frequent assistance with daily life activities	• Progressive cognitive impairment or neurobehavioral changes. • Clinical interview may not be possible. • Complete dependency due to severe functional impact on daily life with impairment in basic activities, including basic self-care.

Adapted from Table 6, Jack et al (2018) [a]Applicable only to individuals in the Alzheimer's continuum that fall into 1 of the 4 biomarker groups: 1) A+T+N+ 2) A+T-N- 3) A+T+N- 4) A+T-N+ where A: Aggregated Aβ or associated pathologic state (CSF Aβ42, or Aβ42/Aβ40 ratio or Amyloid PET), T: Aggregated tau (neurofibrillary tangles) or associated pathologic state (CSF phosphorylated tau or Tau PET) and N: Neurodegeneration or neuronal injury (anatomic MRI, FDG PET or CSF total tau)
For stages 1 to 6: Cognitive test performance may be compared to normative data of the investigators choice, with or without adjustment (choice of the investigators) for age, sex, education, etc.
For stages 2 to 6: Although cognition is the core feature, neurobehavioral changes, for example, changes in mood, anxiety, or motivation may coexist.
For stages 3 to 6: Cognitive impairment may be characterized by presentations that are not primarily amnestic.
CSF: cerebrospinal fluid; FDG: fluorodeoxyglucose; MCI: mild cognitive impairment; MRI: magnetic resonance imaging; PET: positron emission tomography.

Summary of Evidence

The efficacy of Leqembi was evaluated in a double-blind, placebo-controlled, parallel-group dose-finding trial, Study 201 (NCT01767311) in adult individuals with AD (individuals with confirmed presence of amyloid pathology and MCI or mild dementia consistent with Stage 3 and Stage 4 AD). The study assessed three doses across two regimens of Leqembi. Study 201 had a 79-week double-blind, placebo-controlled period, followed by an open-label extension (OLE) period for up to 260 weeks, which was initiated after a gap period (range, 9 to 59 months; mean, 24 months) off treatment. Change from baseline in brain amyloid plaque, as measured by 18F-florbetapir PET and quantified by a composite standard uptake value ratio (SUVR), was assessed in a subset of individuals at Weeks 53 and 79. Compared with placebo, the Leqembi 10 mg/kg biweekly arm demonstrated a statistically significant reduction in brain amyloid plaque at Week 79 (mean difference of −0.31 SUVR or −73.5 Centiloids; P <0.001).

In January 2025, the FDA approved Leqembi for once every four weeks dosing after 18 months of once every two weeks dosing. Based on modeling of observed data from the Phase II study (Study 201) and its long-term extension (LTE) as well as the Clarity AD study (Study 301) and its LTE study. Modeling simulations predict that transitioning to once every four weeks maintenance dosing after 18 months of once every two weeks treatment will maintain clinical and biomarker benefits of therapy. Data from the off-treatment period between the Study 201 (Phase II) core study and LTE showed that discontinuation of treatment is associated with re-accumulation of amyloid PET and plasma and CSF biomarkers, and reversion to placebo rate of clinical decline. For maintenance treatment, once every four weeks dosing regimen may be easier than once every two weeks dosing for individuals and care partners to continue treatment for early AD. Ongoing treatment can slow disease progression and prolong the benefit of therapy, with the goal of helping individuals maintain who they are for longer. In the Clarity AD core study (18 months), the mean change from baseline between the once every two weeks Leqembi treated group and the placebo group was -0.45 (P<0.0001) on the primary endpoint of the Clinical Dementia Rating-Sum of Boxes (CDR-SB) global cognitive and functional scale. Over

three years of treatment across the Clarity AD core study and LTE, Leqembi reduced cognitive decline on the CDR-SB by -0.95 relative to a matched natural history cohort showing clinically meaningful benefit for early AD individuals. A change from 0.5 to 1 on the CDR score domains of Memory, Community Affairs and Home/Hobbies is the difference between slight impairment and loss of independence, such as people's ability to be left alone, remember recent events, participate in daily activities, complete household chores, function independently and engage in hobbies and intellectual interests.

The safety and efficacy of Kisunla was evaluated in TRAILBLAZER-ALZ 2 (NCT04437511; referred to in the prescribing information as Study 1), a Phase 3, double-blind, placebo-controlled, parallel-group study that enrolled 1736 adult participants with early Alzheimer's disease [AD] (confirmed presence of amyloid pathology and mild cognitive impairment [MCI] or mild dementia stage of disease, consistent with Stage 3 and Stage 4 AD); there were 1182 participants in the low/medium tau population (which was a subset of the overall population). There were two primary analysis populations based on tau PET imaging with flortaucipir: 1) a low/medium tau level population (defined by visual assessment and a standardized uptake value ratio [SUVR] of ≥1.10 and ≤1.46), and 2) a combined population of low/medium plus high tau (defined by visual assessment and SUVR >1.46). Participants treated with Kisunla demonstrated a statistically significant reduction in clinical decline on the integrated Alzheimer's Disease Rating Scale (iADRS) compared to placebo at Week 76 in the combined population (2.92, $P<0.0001$) and the low/medium tau population (3.25, $P<0.0001$), which was the primary outcome measured in the study. Individuals treated with Kisunla demonstrated a statistically significant reduction in clinical decline on the Clinical Dementia Rating Scale – Sum of Boxes (CDR-SB) compared to placebo at Week 76 in the combined population (−0.70, $P<0.0001$). There were also statistically significant differences ($P<0.001$) between treatment groups as measured on the Alzheimer's Disease Assessment Scale – 13-item Cognitive Subscale 13 (ADAS-Cog13) and Alzheimer's Disease Cooperative Study – Instrumental Activities of Daily Living (ADCS-iADL) scale at Week 76. Dosing was continued or stopped in response to observed effects on amyloid imaging. The percentages of participants eligible for switch to placebo based on amyloid PET levels at Week 24, Week 52, and Week 76 time points were 17%, 47%, and 69%, respectively. Amyloid PET values may increase after treatment with Kisunla is stopped. According to the Kisunla Prescribing Information, there are no data beyond the 76-week duration of TRAILBLAZER-ALZ 2 to guide whether additional dosing with Kisunla may provide longer-term clinical benefit. Results showed that, at 18 months, Kisunla slowed cognitive and functional decline by up to 35% compared to placebo and reduced participants' risk of progressing to the next clinical stage of disease by up to 39%.

Safety

For Leqembi, in Study 201 the most common adverse reactions reported in at least 5% of individuals treated with Leqembi 10 mg/kg biweekly (n = 161) and having at least 2% higher incidence than in individuals on placebo (n = 245) were infusion-related reactions (Leqembi 20%; placebo 3%), headache (Leqembi 14%; placebo 10%), ARIA-E (Leqembi 10%; placebo 1%), cough (Leqembi, 9%; placebo, 5%) and diarrhea (Leqembi, 8%; placebo, 5%). The most common adverse reactions leading to discontinuation of Leqembi were infusion-related reactions (e.g. flu-like symptoms, nausea, vomiting and changes in blood pressure), which led to discontinuation in 2% (4/161) of individuals treated with Leqembi compared to 1% (2/245) of individuals on placebo. Individuals were excluded from enrollment in Study 201 for baseline use of anticoagulant medications. Antiplatelet medications such as aspirin and clopidogrel were allowed. Individuals who received Leqembi and an antithrombotic medication (i.e. aspirin, other antiplatelets, or anticoagulants) did not have an increased risk of amyloid-related imaging abnormalities (ARIA) with hemosiderin deposition (ARIA-H; includes microhemorrhage and superficial siderosis) compared to individuals who received placebo and an antithrombotic medication. The majority of exposures to antithrombotic medications were to aspirin; few individuals were exposed to other antiplatelet drugs or anticoagulants, limiting any meaningful conclusions about the risk of ARIA or intracerebral hemorrhage in individuals taking other antiplatelet drugs or anticoagulants. Because intracerebral hemorrhages greater than 1 cm in diameter have been observed in individuals taking Leqembi, additional caution should be exercised when considering the administration of antithrombotics or a thrombolytic agent (e.g. tissue plasminogen activator [tPA]) to an individual already being treated with Leqembi. Additionally, individuals were excluded from enrollment in Study 201 for the following risk factors for intracerebral hemorrhage: prior cerebral hemorrhage greater than 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, and severe small vessel or white matter disease. Caution should be exercised when considering the use of Leqembi in individuals with these risk factors. The approved label does not contain a Boxed Warning or require a REMS program. However, it does include a warning about ARIA with a recommendation for MRI monitoring for signs and symptoms and discussion of concomitant antithrombotic medication use. Of concern, three deaths have been reported in the OLE trial of Leqembi (ALZFORUM, 2022); two individuals had received anticoagulants, and another had a history of treatment with tPA.

As noted in the Kisunla Prescribing Information, testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA. In TRAILBLAZER-ALZ 2,

17% (143/850) of participants 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 (55% on Kisunla vs. 22% on placebo) than in heterozygotes (36% on Kisunla vs. 13% on placebo) and noncarriers (25% on Kisunla vs. 12% on placebo). Symptomatic ARIA occurred in 6% (52/853) of individuals treated with Kisunla. Clinical symptoms associated with ARIA resolved in approximately 85% (44/52) of these participants. Among participants treated with Kisunla, symptomatic ARIA-E occurred in 8% of ApoE ε4 homozygotes compared with 7% of heterozygotes and 4% of noncarriers.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Institute for Clinical and Economic Review

The Institute for Clinical and Economic Review (ICER) evaluated the effectiveness and value of lecanemab for Alzheimer's disease and released their final evidence report on April 17, 2023. ICER rated the current evidence to be promising but inconclusive (P/I) to determine whether lecanemab provides a net health benefit over supportive care alone in individuals with mild cognitive impairment due to Alzheimer's disease or mild Alzheimer's disease.

Regulatory Status

In January 2023, lecanemab (Leqembi; Eisai) was approved by the US FDA for the treatment of Alzheimer's disease. On July 2, 2024, donanemab (Kisunla; Lilly) was approved by the US FDA for the treatment of Alzheimer's disease. In August 2025, lecanemab (Leqembi Iqlik; Eisai) was approved by the US FDA for the ongoing maintenance treatment of Alzheimer's disease.

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History

Date	Comments
10/01/21	New policy, approved September 14, 2021. The use of Aduhelm (aducanumab) is considered investigational for all indications including treatment of Alzheimer's disease. Added HCPCS code J3590 to report Aduhelm.
1/1/22	Coding update, Added HCPCS code J0172 and removed HCPCS code J3590.
12/01/22	Annual Review, approved November 21, 2022. No changes to policy statement. Changed the wording from "patient" to "individual" throughout the policy for standardization.
05/01/23	Annual Review, approved April 19, 2023. No changes to policy statement. The use of Leqembi (lecanemab-irmb) is considered investigational for all indications including treatment of Alzheimer's disease. Added HCPCS code to report Leqembi.
08/01/23	Coding update. Added HCPCS code J0174 for Leqembi. Removed UNL code J3590 (previously used to report Leqembi)
05/01/24	Annual Review, approved April 9, 2024. Added coverage criteria for Leqembi (lecanemab-irmb) for the treatment of Alzheimer's disease.
01/01/25	Interim Review, approved December 10, 2024. Added coverage criteria for Kisunla (donanemab-azbt) for the treatment of Alzheimer's disease. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information. The following policy criteria will become effective on April 6, 2025, following 90-day provider notification. Updated criteria for Leqembi. Updated coverage criteria for Leqembi with inclusion of test results that indicate mild cognitive impairment or mild Alzheimer's disease dementia and added requirement for testing for ApoE ε4 status and that potential ARIA risks have been discussed. Added HCPCS code J0175 for Kisunla.

Date	Comments
05/01/25	Annual Review, approved April 21, 2025. Removed Aduhelm (aducanumab) from the policy as the manufacturer has discontinued the product. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Removed HCPCS J0172, as Aduhelm is no longer manufactured.
08/01/25	Interim Review, approved July 7, 2025. Updated Leqembi (lecanemab-irmb) criteria to include reference to dosing of 10 mg/kg once every 4 weeks after 18 months of initial therapy.
11/01/25	Interim Review, approved October 14, 2025. Added coverage criteria for Leqembi Iqlik (lecanemab-irmb).
04/01/26	Coding update. Update descriptor for HCPCS code J0174, effective April 1, 2026.
07/01/26	Annual Review, approved June 22, 2026. Removed reference to non-formulary exception reviews. Removed BCBSA Reference Policy: 5.01.538 as policy has been put in sunset status.
09/01/26	Interim Review, approved August 11, 2026. Updated the criteria for Leqembi Iqlik (lecanemab-irmb) removing the requirement for 18 months of prior Leqembi IV therapy, clarified the dose limit, and added a quantity limit per 28 days.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.