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Donanemab-azbt

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Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current peer-reviewed scientific literature. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and acceptable standards of medical practice. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For HCSC members residing in the state of Ohio, § 3923.60 requires any group or individual policy (Small, Mid-Market, Large Groups, Municipalities/Counties/Schools, State Employees, Fully-Insured, PPO, HMO, POS, EPO) that covers prescription drugs to provide for the coverage of any drug approved by the U. S. Food and Drug Administration (FDA) when it is prescribed for a use recognized as safe and effective for the treatment of a given indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature even if the FDA has not approved the drug for that indication. Medical literature support is only satisfied when safety and efficacy has been confirmed in two articles from major peer-reviewed professional medical journals that present data supporting the proposed off-label use or uses as generally safe and effective. Examples of accepted journals include, but are not limited to, Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), and Lancet. Accepted

study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Evidence limited to case studies or case series is not sufficient to meet the standard of this criterion. Coverage is never required where the FDA has recognized a use to be contraindicated and coverage is not required for non-formulary drugs.

Coverage

Initial Therapy

Donanemab-azbt (Kisunla) **may be considered medically necessary** for the treatment of Alzheimer's Disease (AD) when ALL the following criteria are met:

1. The medication is prescribed by or in consultation with a neurologist or neuropsychiatrist; AND
2. Individual is aged 50 years or older; AND
3. Individual has mild cognitive impairment due to AD or mild AD dementia; AND
4. Individual has objective evidence of cognitive impairment at baseline; AND
5. Individual has positive amyloid load as indicated by one of the following:
    - Positron emission tomography (PET) assessment of imaging agent uptake into brain; or
    - Cerebrospinal fluid (CSF) assessment of amyloid β (Aβ1-42); AND
6. Individual has a baseline brain magnetic resonance imaging (MRI) prior to initiating treatment (within one year); AND
7. Individual must have one of the following scores at baseline on any of the following assessment tools:
    - Clinical Dementia Rating-Global Score (CDR-GS) of 0.5 or 1 (**see NOTE 1**); or
    - Mini-Mental Status Examination (MMSE) score of 21-30 (**see NOTE 2**); AND
8. Kisunla will NOT be used in combination with any other amyloid beta-directed antibodies [e.g., aducanumab (Aduhelm), lecanemab (Leqembi)].

Continuation of Therapy

Donanemab-azbt (Kisunla) **may be considered medically necessary** for the treatment of Alzheimer's Disease (AD) when ALL the following criteria are met:

1. Criterial for initial therapy was met; AND
2. Individual has a positive clinical response as evidenced by improvement or stabilization in score in any of the following measures:
    - Clinical Dementia Rating-Global Score (CDR-GS) (i.e., score of 0.5 or 1) (**see NOTE 1**); or
    - Mini-Mental Status Examination (MMSE) (i.e., score of 21-30) (**see NOTE 2**); AND
3. MRI is obtained prior to the 5th, 7th, and 14th infusions to monitor for amyloid related imaging abnormalities (ARIA).

Donanemab-azbt (Kisunla) **is considered experimental, investigational and/or unproven** for all other indications, including but not limited to, the following:

- Neurological conditions that may be contributing to cognitive impairment above and beyond that caused by Alzheimer's Disease (AD); OR

- Requirement for therapeutic anticoagulation (e.g., anticoagulants, antiplatelets) except for aspirin at a prophylaxis dose or less (no more than 325mg daily); OR
- History of transient ischemic attacks (TIA), stroke, or seizures within 12 months of screening; OR
- Bleeding disorder that is not under adequate control (including a platelet count less than 50,000 or international normalized ration [INR] greater than 1.5).

NOTE 1: Clinical Dementia Rating-Global Score (CDR-GS)
The CDR-GS is a semi-structured interview of the patient and a reliable informant or collateral source (e.g., family member). It is scored on a 5-point scale and characterizes six domains of cognitive and functional performance applicable to Alzheimer disease and related dementias: memory, orientation, judgement and problem solving, community affairs, home and hobbies, and personal care. The score corresponds to the following classifications:
• 0 = Normal
• 0.5 = Very Mild Dementia
• 1 = Mild Dementia
• 2 = Moderate Dementia
• 3 = Severe Dementia

NOTE 2: Mini-Mental Status Examination (MMSE)
The MMSE is scored on a 30-point scale, with items that assess orientation (temporal and spatial, 10 points); memory (registration and recall, 6 points); attention/concentrations (5 points); language (verbal and written, 8 points); and visuospatial function (1 point), with the score corresponding to the following classifications:
• 25-30 suggests normal cognition;
• 20-25 suggests mild dementia;
• 10-20 suggests moderate dementia;
• 0-10 suggests severe dementia.

Policy Guidelines

None.

Description

Alzheimer's Disease
Alzheimer's disease (AD) 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 AD 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 6.9 million Americans aged 65 and older are currently living with AD dementia, and the number is projected to reach over 13.8 million by 2060. (1)

Pathophysiology

The pathologic hallmarks of AD are extracellular deposits of amyloid beta, 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 AD is not well understood. Generally referred to as the "amyloid hypothesis," it is believed that aggregation of amyloid beta oligomers in the brain leads to amyloid plaques, and it 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. (2, 3)

Salient known risk factors for AD are older age, genetics, and family history. Of these, increasing age has the largest known impact on risk of developing AD. While several genes have been found to increase the risk of AD, the ε4 allele of the apolipoprotein E (ApoE) gene is the strongest known genetic risk factor. (4, 5) Having a single copy of the gene is associated with a 2- to 3-fold increase in developing AD while 2 copies of the gene may increase risk of AD by as much as 15 times. (6) Approximately two-thirds of pathology-confirmed AD cases are ε4 positive (homozygous or heterozygous), compared with about 15% to 20% of the general population. (5) Autosomal dominant genetic mutations are estimated to account for less than 1% of AD cases. (7)

The pathophysiological changes and clinical manifestations of AD are progressive and occur along a continuum, and accumulation of amyloid beta may begin 20 years or more before symptoms arise. (8) The 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 continuum. This staging scheme reflects the sequential evolution of AD from an initial stage characterized by the appearance of abnormal AD 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 This numeric staging scheme is very similar to the categorical system for staging AD outlined in the Food and Drug Administration (FDA) guidance for industry pertaining to developing drugs for treatment of early AD. (9)

Clinical criteria for diagnosing AD are informed by the NIA-AA 2011 guidelines. (10, 11) Mild cognitive impairment (MCI) lies between the cognitive changes of normal aging and dementia. Mild cognitive impairment is a syndrome in which persons experience memory loss (amnestic MCI) or loss of thinking skills other than memory loss (non-amnestic MCI), to a greater extent than expected for age, but without impairment of day-to-day functioning. (10) Individuals with MCI are at increased risk of developing dementia (whether from AD or another etiology), but many do not progress to dementia, and some get better. Dementia is a syndrome involving

cognitive and behavioral impairment in an otherwise alert patient, due to a number of neurological diseases, alone or combined. It is not a specific cause or disease process itself. The impairment must involve a minimum of 2 domains (memory, reasoning, visuospatial abilities, language or personality behaviors), impact daily functioning, represent a decline from previous levels of functioning, not be explainable by delirium (a temporary state of mental confusion and fluctuating consciousness from various causes) or a major psychiatric disorder, and be objectively documented by a "bedside" mental status exam (e.g., the mini-mental status exam) or neuropsychological testing. (11) These guidelines describe core clinical criteria for "all-cause" dementia and "probable AD" dementia. Briefly, "probable AD" dementia must first meet the criteria for "all-cause" dementia. Additionally, there must be: (a) insidious onset; (b) documented worsening of cognition; (c) exclusion of major concomitant cerebrovascular disease (as most individuals with AD have some level of this as well); and (d) exclusion of alternative diagnoses (e.g., dementia with Lewy bodies, behavioral variant frontotemporal dementia, progressive aphasia, or other neurological disease associated with dementia). A clinical diagnosis of "possible AD" dementia would meet the criteria for "probable AD" with the exception of having an "atypical course" (e.g., sudden rather than insidious onset) or an "etiologically mixed presentation."

Current Treatment

Current treatment goals for patients with AD 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). (12) Non-pharmacologic treatments include physical activity (13, 14) 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). (15) Currently, FDA-approved drugs for AD 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 these agents are associated with significant side effects. (15, 16)

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

Stage	Severity	Clinical Features
Stage 1	Pre-clinical	• Performance within expected range on objective cognitive tests. • No evidence of recent cognitive decline or new neurobehavioral symptoms.

Stage 2	Pre-clinical	• Normal performance within expected range on objective cognitive tests. • Transitional cognitive decline (change from individual baseline within past 1 to 3years, 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.
Stage 3	MCI due to Alzheimer Disease	• 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.
Stage 4	Mild Dementia	• 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.
Stage 5	Moderate Dementia	• 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.
Stage 6	Severe Dementia	• 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) (17)

[a] Applicable only to individuals in the Alzheimer 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 amyloid beta or associated pathologic state (CSF amyloid $beta_{42}$, or amyloid $beta_{42}$/amyloid $beta_{40}$ 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 investigator's 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.

Donanemab-azbt (Kisunla)
Donanemab-azbt is a humanized immunoglobulin gamma 1 (IgG1) monoclonal antibody directed against insoluble N-truncated pyroglutamate amyloid beta. Donanemab-azbt reduces amyloid beta plaques. (18)

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), which can be observed on MRI as brain edema or sulcal effusions, and ARIA with hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis. ARIA can occur spontaneously in patients with Alzheimer's disease, particularly in patients with MRI findings suggestive of cerebral amyloid angiopathy, such as pretreatment microhemorrhage or superficial siderosis. ARIA-H associated with monoclonal antibodies directed against aggregated forms of beta amyloid generally occurs in association with an occurrence of ARIA-E. ARIA-H of any cause and ARIA-E can occur together. (18)

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 greater than 1 cm in diameter have occurred in patients treated with Kisunla. (18)

Regulatory Status
In 2024, the U.S. Food and Drug Administration (FDA) approved donanemab-azbt (Kisunla, Eli Lilly & Co.) for the treatment of Alzheimer's disease. Treatment with Kisunla should be initiated in patients with mild cognitive impairment or mild dementia stage of disease, the population in which treatment was initiated in the clinical trials. (18)

Rationale

Donanemab-azbt (Kisunla) (18)
The efficacy of Donanemab-azbt (Kisunla) was evaluated in a double-blind, placebo-controlled, parallel-group study (Study 1, NCT04437511) in patients with Alzheimer's disease (patients with confirmed presence of amyloid pathology and mild cognitive impairment or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease). Patients were enrolled with a Mini-Mental State Examination (MMSE) score of ≥20 and ≤28 and had a progressive change in memory function for at least 6 months. Patients were included in the study based on visual assessment of tau positron emission tomography (PET) imaging with flortaucipir and standardized uptake value ratio (SUVR). Patients were enrolled with or without concomitant approved therapies (cholinesterase inhibitors and the N-methyl-D-aspartate

antagonist memantine) for Alzheimer's disease. Patients could enroll in an optional, long-term extension.

In Study 1, 1736 patients were randomized 1:1 to receive 700 mg of Kisunla every 4 weeks for the first 3 doses, and then 1400 mg every 4 weeks (N = 860) or placebo (N = 876) for a total of up to 72 weeks. The treatment was switched to placebo based on amyloid PET levels measured at Week 24, Week 52, and Week 76. If the amyloid plaque level was <11 Centiloids on a single PET scan or 11 to <25 Centiloids on 2 consecutive PET scans, the patient was eligible to be switched to placebo.

Additionally, dose adjustments were allowed for treatment-emergent ARIA or symptoms that then showed ARIA-E or ARIA-H on MRI.

At baseline, mean age was 73 years, with a range of 59 to 86 years. Of the total number of patients randomized, 68% had low/medium tau level and 32% had high tau level; 71% were ApoE ε4 carriers and 29% were ApoE ε4 noncarriers. Fifty-seven percent of patients were female, 91% were White, 6% were Asian, 4% were Hispanic or Latino, and 2% were Black or African American.

The primary efficacy endpoint was change in the integrated Alzheimer's Disease Rating Scale (iADRS) score from baseline to 76 weeks. The iADRS is a combination of two scores: the Alzheimer's Disease Assessment Scale-Cognitive subscale (ADAS-Cog13) and the Alzheimer's Disease Cooperative Study – instrumental Activities of Daily Living (ADCSiADL) scale. The total score ranges from 0 to 144, with lower scores reflecting worse cognitive and functional performance. Other efficacy endpoints included Clinical Dementia Rating Scale – Sum of Boxes (CDR-SB), ADAS-Cog13, and ADCS-iADL.

There were two primary analysis populations based on tau PET imaging with flortaucipir: 1) low/medium tau level population (defined by visual assessment and SUVR of ≥1.10 and ≤1.46), and 2) combined population of low/medium plus high tau (defined by visual assessment and SUVR >1.46) population.

Patients treated with Kisunla demonstrated a statistically significant reduction in clinical decline on iADRS compared to placebo at Week 76 in the combined population (2.92, $p<0.0001$) and the low/medium tau population (3.25, $p<0.0001$).

Patients treated with Kisunla demonstrated a statistically significant reduction in clinical decline on CDR-SB compared to placebo at Week 76 in the combined population (-0.70, $p<0.0001$) (see Table 2). There were also statistically significant differences ($p<0.001$) between treatment groups as measured by ADAS-Cog13 and ADCS-iADL at Week 76 (see Table 2).

Dosing was continued or stopped in response to observed effects on amyloid imaging. The percentages of patients eligible for switch to placebo based on amyloid PET levels at Week 24, Week 52, and Week 76 timepoints were 17%, 47%, and 69%, respectively. Amyloid PET values

may increase after treatment with donanemab is stopped. There is no data beyond the 76-week duration of Study 1 to guide whether additional dosing with Kisunla may be needed for longer-term clinical benefit.

Table 2. Efficacy Analysis Results in Combined Population at Week 76

Clinical Endpoints	Kisunla (N=860)	Placebo (N=876)
CDR-SB[a]		
Mean baseline	3.92	3.89
Adjusted mean change from baseline	1.72	2.42
Difference from placebo (%)[c]	-0.70 (29%) P<0.0001	--
ADAS-Cog$_{13}$[b]		
Mean baseline	28.53	29.16
Adjusted mean change from baseline	5.46	6.79
Difference from placebo (%)[c]	-1.33 (20%) P=0.0006	--
ADCS-iADL[c]		
Mean baseline	47.96	47.98
Adjusted mean change from baseline	-4.42	-6.13
Difference from placebo (%)[c]	1.70 (28%) P=0.0001	--

ADAS-Cog13: Alzheimer's Disease Assessment Scale – 13-item Cognitive Subscale; ADCS-iADL: Alzheimer's Disease Cooperative Study – instrumental Activities of Daily Living subscale; CDR-SB: Clinical Dementia Rating Scale – Sum of Boxes.

[a] Assessed using MMRM analysis.

[b] Assessed using NCS2 analysis.

[c] Percent slowing of decline relative to placebo: difference of adjusted mean change from baseline between treatment groups divided by adjusted mean change from baseline of placebo group at Week 76.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	J0175

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

References

1. 2024 Alzheimer's disease facts and figures. Alzheimers Dement. 2024 Apr 30; 20(5):3708-3821. PMID 38689398
2. Alzheimer's Association. 2024 Alzheimer's disease facts and figures. Published 2024. Available at <https://www.alz.org> (accessed November 4, 2024).
3. Roberts RO, Aakre JA, Kremers WK, et al. Prevalence and Outcomes of Amyloid Positivity Among Persons Without Dementia in a Longitudinal, Population-Based Setting. JAMA Neurol. Aug 01 2018; 75(8):970-979. PMID 29710225
4. Elias-Sonnenschein LS, Viechtbauer W, Ramakers IH, et al. Predictive value of APOE-4 allele for progression from MCI to AD-type dementia: a meta-analysis. J Neurol Neurosurg Psychiatry. Oct 2011; 82(10):1149-1156. PMID 21493755
5. Mattsson N, Groot C, Jansen WJ, et al. Prevalence of the apolipoprotein E 4 allele in amyloid positive subjects across the spectrum of Alzheimer's disease. Alzheimers Dement. Jul 2018; 14(7):913-924. PMID 29601787
6. Farrer LA, Cupples LA, Haines JL, et al. Effects of age, sex, and ethnicity on the association between apolipoprotein E genotype and Alzheimer disease. A meta-analysis. APOE and Alzheimer Disease Meta Analysis Consortium. JAMA. Oct 1997; 278(16):1349-1356. PMID 9343467
7. Bekris LM, Yu CE, Bird TD, et al. Genetics of Alzheimer disease. J Geriatr Psychiatry Neurol. Dec 2010; 23(4):213-227. PMID 21045163
8. Vermunt L, Sikkes SAM, van den Hout A, et al. Duration of preclinical, prodromal, and dementia stages of Alzheimer's disease in relation to age, sex, and APOE genotype. Alzheimers Dement. Jul 2019; 15(7):888-898. PMID 31164314
9. FDA – U.S. Food and Drug Administration. Early Alzheimers disease: developing drugs for treatment guidance for industry. Draft Guidance; Clinical/Medical Revision 2 March 2024. Published online Feb 29, 2018. Available at <https://www.fda.gov> (accessed on November 4, 2024).
10. Albert MS, DeKosky ST, Dickson D, et al. The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. May 2011; 7(3):270-279. PMID 21514249
11. McKhann GM, Knopman DS, Chertkow H, et al. The diagnosis of dementia due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. May 2011; 7(3):263-269. PMID 21514250
12. Reuben DB, Tan ZS, Romero T, et al. Patient and Caregiver Benefit From a Comprehensive Dementia Care Program: 1-Year Results From the UCLA Alzheimer's and Dementia Care Program. J Am Geriatr Soc. Nov 2019; 67(11):2267-2273. PMID 31355423
13. Gronek P, Balko S, Gronek J, et al. Physical Activity and Alzheimer's Disease: A Narrative Review. Aging Dis. Dec 2019; 10(6):1282-1292. PMID 31788339

14. Du Z, Li Y, Li J, et al. Physical activity can improve cognition in patients with Alzheimer's disease: a systematic review and meta-analysis of randomized controlled trials. Clin Interv Aging. 2018; 13:1593-1603. PMID 30233156
15. Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic management of behavioral symptoms in dementia. JAMA. Nov 21 2012; 308(19):2020-2029. PMID 23168825
16. Kaduszkiewicz H, Zimmermann T, Beck-Bornholdt HP, et al. Cholinesterase inhibitors for patients with Alzheimer's disease: systematic review of randomised clinical trials. BMJ. Aug 06 2005; 331(7512):321-327. PMID 16081444
17. Jack CR, Bennett DA, Blennow K, et al. NIA-AA research framework: Toward a biological definition of Alzheimer's disease. Alzheimers Dement. Apr 2018; 14(4):535-562. PMID 29653606
18. U.S. Food and Drug Administration, Drugs@FDA. Highlights of Prescribing Information: Kisunla (donanemab-azbt). (July 2024). Available at <https://www.accessdata.fda.gov> (accessed November 4, 2024).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
03/15/2025	New medical document. Donanemab-azbt (Kisunla) may be considered medically necessary for the treatment of Alzheimer’s disease in individuals meeting the initial or continuation therapy criteria listed in coverage. Donanemab-azbt (Kisunla) is considered experimental, investigational and/or unproven for all other indications.