November 22, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: National Coverage Analysis (NCA) for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Dear Administrator Brooks-LaSure:

The undersigned are writing jointly to share our recommendations regarding Medicare coverage for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease (AD). We have written to the Centers for Medicare & Medicaid Services (CMS) individually on this topic but wanted to emphasize the alignment among our three organizations on the following points.

First, we strongly urge CMS to limit any national coverage determination (NCD) to aducanumab, the only monoclonal antibody product currently approved by the Food and Drug Administration (FDA) for the treatment of Alzheimer's disease, and not make a determination at this time for the entire class of products. The clinical evidence on aducanumab has significant limitations including the lack of data for under-represented populations, many of which have a higher prevalence of AD. The insufficiency of the aducanumab data should not be the basis for determining whether future products, which are expected to have a more robust evidence base, are available to Medicare beneficiaries.

Second, we recommend that if Medicare covers aducanumab, the coverage should be restricted to patients who are likely to benefit from the therapy. Eligible patients should have both (1) a diagnosis of mild cognitive impairment (MCI) or mild stage AD confirmed by neurologic/neurocognitive examination similar to that required in the Phase 3 clinical trials and (2) confirmed presence of amyloid plaque in the brain. The diagnosis of MCI or mild stage AD can be determined using standardized dementia scales and functional measures, such as instrumental activities of daily living and activities of daily living. To confirm the presence of

amyloid plaque, the Phase 3 clinical trials used beta amyloid PET scans but an outdated NCD severely limits coverage of beta amyloid PET for Medicare beneficiaries to CMS approved clinical trials. We strongly urge CMS to remove this NCD which prevents Medicare beneficiaries and the physicians treating them from accessing the diagnostic information needed to make an informed decision about receiving aducanumab. We note that, while the presence of beta amyloid in the brain can also be determined by testing cerebrospinal fluid, many patients may not be candidates for a lumbar puncture or may refuse to undergo a lumbar puncture.

To avoid exposing patients who are not likely to benefit from aducanumab to its potentially serious side effects, Medicare should explicitly non-cover aducanumab for patients who do not meet the above criteria. This includes patients for whom aducanumab is contraindicated because they have a primary diagnosis of cerebral amyloid angiopathy or use anti-coagulation therapy as well as patients with more advanced AD or non-Alzheimer's dementia. We also recommend that CMS specify criteria for when a patient who is receiving aducanumab should discontinue treatment, for example, when the patient progresses from mild to moderate AD.

Third, the most important health outcome for patients on aducanumab is maintaining cognitive and functional ability and a meaningful slowing of the rate of decline in these areas. CMS should require consideration of those factors in determining whether Medicare should limit the length of coverage of aducanumab if the patient does not maintain cognitive and functional ability.

To ensure the appropriate identification of patients who may benefit from aducanumab and those who should remain on the therapy if it is initiated, CMS should require treatment decisions be made by physicians who are engaged in the principal care of the patient. Ideally a shared decision would be made by the patient and their caregiver in conjunction with a physician who specializes in treating this patient population, such as a neurologist, geriatrician, or geriatric psychiatrist.

We would be happy to meet with you to discuss these recommendations. Please contact Paul Rudolf at paul.rudolf@arnoldporter.com or call 202-942-6426, if you have any questions.

Sincerely,

American Academy of Neurology
American Geriatrics Society
Society of Nuclear Medicine and Molecular Imaging