MDForLives

THE GLOBAL PULSE OF HEALTHCARE · NEUROLOGY INSIGHT REPORT

Anti-Amyloid Therapy in Early Alzheimer’s: Where Neurology Practice Gets Stuck

A detailed view of how neurologists are navigating the shift from blood-based Alzheimer’s biomarkers to treatment decisions, including amyloid confirmation, payer access, ApoE counseling, ARIA management, early-stage patient selection, post-clearance strategy, referral capacity, and the next generation of anti-amyloid care.

Detection → Confirmation → Risk Assessment → Treatment → Monitoring

55 Survey records	**6** Countries represented USA · UK · Canada · Italy · France · Germany	**70.9%** Completion rate

WHY THIS REPORT

The anti-amyloid era has changed the neurologist’s workload before it has simplified the neurologist’s decision

Alzheimer’s care is undergoing a rare convergence of diagnostic and therapeutic change. Blood-based biomarkers can now detect amyloid-related pathology with levels of performance that are increasingly useful in clinical workflows, and disease-modifying anti-amyloid therapies have created a treatment pathway for selected patients in the earliest symptomatic stages. That combination moves patients into neurology earlier, often before the degree of cognitive and functional impairment makes the treatment decision obvious.

The external clinical environment is moving quickly. The Alzheimer’s Association released an evidence-based blood-based biomarker clinical practice guideline in 2025 for specialty-care evaluation of people with cognitive impairment. The guideline uses test-performance thresholds to distinguish when a blood biomarker can function as a triage tool and when a sufficiently accurate test can substitute for amyloid PET or CSF in an appropriate diagnostic workup. The FDA cleared the first Alzheimer’s blood test in May 2025 and has since cleared additional p-tau217 assays, including another single-biomarker test in August 2026. Current cleared tests are intended to aid diagnosis in patients with cognitive impairment, not to serve as universal screening tools for asymptomatic adults.

Treatment adds an equally demanding safety and access architecture. FDA prescribing information for lecanemab and donanemab places initiation in mild cognitive impairment or mild dementia with confirmed amyloid pathology, requires baseline MRI and scheduled surveillance for ARIA, and states that ApoE ε4 testing should be performed before treatment to inform risk. In the United States, Medicare coverage of traditionally approved anti-amyloid monoclonal antibodies operates through a coverage-with-evidence-development framework that includes qualifying registries. Other countries use different access models, but across settings the neurologist must connect diagnosis, risk, capacity, affordability, and patient preference into one coherent pathway.

> **Methodology and data note.** Audience: neurologists. Survey ID 8944880. The source export contains 55 survey records, a 70.9% completion rate, and geography entries from the USA, UK, Canada, Italy, France, and Germany. Structured clinical questions have reported bases ranging from 40 to 42 responses. The hidden country-punching item is used only for geography metadata. Administrative tracking, bad-ID, required-text, after-question, and honeypot fields are excluded from interpretation.

EXECUTIVE SUMMARY

Six signals that define the treatment-readiness gap in early Alzheimer’s care

INSIGHT 01

Payer friction is the dominant scaling barrier

57.1% name prior authorization, Medicare, or insurance hurdles as the single greatest operational bottleneck.

INSIGHT 02

ApoE testing is treated as a core prescribing step

61.0% say they would not prescribe an anti-amyloid DMT without knowing ApoE4 carrier status.

INSIGHT 03

Real-world ARIA management is conservative

73.2% would pause treatment, follow serial MRI to resolution, and cautiously re-challenge after low-grade asymptomatic ARIA-E.

INSIGHT 04

MCI is the clearest expected benefit window

56.1% select mild cognitive impairment as the population most likely to show the most profound clinical benefit.

INSIGHT 05

Post-clearance management is not settled

36.6% prefer stopping DMT while using serial blood biomarkers and retreating only if levels rise.

INSIGHT 06

Safety leads the future wish list

42.5% prioritize next-generation DMTs with substantially lower ARIA risk over convenience or AI support.

01

BLOOD-BASED BIOMARKER REFERRALS

Positive blood tests are already entering neurology, but the referral stream is not yet standardized

31.0% receive primary-care referrals after a positive blood-based biomarker a few times a quarter.

CONTEXT

Blood-based biomarkers have moved quickly from research toward clinical use. The FDA cleared the first Alzheimer’s blood test in 2025, and additional assays have followed. At the same time, primary care remains the place where many patients first raise memory concerns, which makes the handoff to neurology a crucial part of any early-detection model.

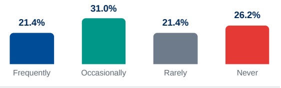
WHAT THE DATA SHOWS

Occasional referrals are the largest response at 31.0%. Another 26.2% say primary care in their network does not currently order these tests. Frequent referrals are reported by 21.4%, and 21.4% say they are rare because most referrals still rely on clinical symptoms rather than early blood testing.

THE INSIGHT

The distribution shows an uneven adoption curve rather than a single new standard. Some neurologists are already managing biomarker-driven referrals often enough for them to become a workflow issue, while others are still working inside a symptom-led pathway. That variation can reflect local test availability, primary-care confidence, referral criteria, payer rules, and specialist access.

Frequency of primary-care referrals after a positive blood-based biomarker



WHY IT MATTERS

As blood testing becomes easier, the referral question becomes more important than the testing question. Neurology needs enough information to distinguish a patient who needs specialist diagnostic clarification from one who needs confirmatory amyloid testing, one who is potentially treatment-eligible, and one whose blood result should not trigger an anti-amyloid pathway at all.

02

CONFIRMATION AFTER A POSITIVE BBM

The blood result is becoming more actionable, but neurologists still differ on how much confirmation is enough before therapy

35.7% require CSF analysis before considering a disease-modifying therapy after a symptomatic patient has a positive blood biomarker.

CONTEXT

Amyloid confirmation has historically relied on PET or CSF. Blood biomarkers create the possibility of a less invasive, more scalable route, but their clinical role depends on the performance of the specific test and whether it is being used for triage or as a substitute for established amyloid-confirmation methods.

WHAT THE DATA SHOWS

CSF is the leading single response at 35.7%. A validated high-accuracy blood biomarker combined with clinical MRI is considered sufficient by 26.2%. Amyloid PET is required by 19.0%, and another 19.0% require both PET and CSF to establish absolute diagnostic certainty.

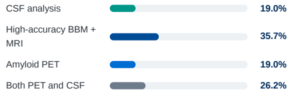
THE INSIGHT

The 2025 Alzheimer's Association guideline is directly relevant because it frames BBM use around performance thresholds. A test meeting a triage threshold can guide who proceeds to PET or CSF, while a test meeting a higher accuracy threshold can substitute for those modalities in an appropriate specialty-care workup. The survey shows that real-world neurologists have not yet converged on one confirmatory threshold.

WHY IT MATTERS

This variation affects time, cost, patient burden, and treatment speed. A blood test can only shorten the pathway if the service has already defined which assay performance is accepted, which clinical presentation qualifies, when MRI adds sufficient context, and when PET or CSF remains necessary.

Confirmatory testing required before considering anti-amyloid therapy



03

OPERATIONAL ACCESS

The largest bottleneck is not infusion capacity or MRI access. It is getting the treatment pathway authorized.

57.1% identify payer friction, prior authorization delays, and Medicare or insurance hurdles as the single greatest barrier to scaling anti-amyloid treatment.

CONTEXT

Anti-amyloid therapy is resource-intensive even before the drug is administered. A treatment candidate may need specialist assessment, amyloid confirmation, ApoE counseling and testing, baseline MRI, documentation of eligibility, coverage approval, infusion or injection planning, and scheduled surveillance imaging. Each step can create a separate point of delay.

WHAT THE DATA SHOWS

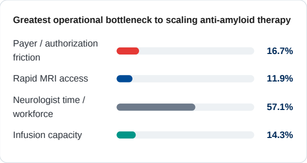
Payer friction dominates at 57.1%. Lack of rapid MRI access for ARIA monitoring is 16.7%, neurologist workforce shortages and inadequate time for complex shared decision-making are 14.3%, and infusion center capacity and scheduling constraints are 11.9%.

THE INSIGHT

The most selected barrier is administrative and financial rather than purely clinical. In the United States, CMS coverage for traditionally approved anti-amyloid monoclonal antibodies includes a registry-based coverage-with-evidence-development process for eligible Medicare beneficiaries. Private insurance requirements and non-U.S. reimbursement pathways differ, but the survey suggests that access mechanics are shaping whether eligible patients can actually reach treatment.

WHY IT MATTERS

For the neurologist, payer friction consumes clinical time because authorization often depends on assembling proof of stage, amyloid pathology, safety eligibility, and planned monitoring. A scalable model needs standardized documentation, clear benefit verification, predictable authorization pathways, and staff who can manage those steps without turning every new treatment start into a bespoke administrative project.


Greatest operational bottleneck to scaling anti-amyloid therapy

---

04

APOE AND RISK COUNSELING

ApoE testing has become part of treatment readiness because ARIA risk changes the meaning of the consent conversation

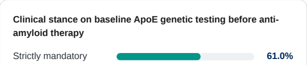
61.0% say ApoE testing is strictly mandatory before they would prescribe an anti-amyloid disease-modifying therapy.

CONTEXT

ApoE genotyping in this setting is not simply a diagnostic exercise. It informs the probability of ARIA and changes how clinicians discuss treatment risk. FDA prescribing information for both lecanemab and donanemab states that ApoE ε4 testing should be performed before treatment to inform ARIA risk and that the implications of genetic testing should be discussed with patients.

WHAT THE DATA SHOWS

Strictly mandatory is the leading stance at 61.0%. Another 26.8% highly recommend testing but would prescribe without it if the patient declines. Only 4.9% restrict ApoE testing to strong family history or early-onset presentations, and 7.3% do not routinely order it because it does not change their baseline treatment indication.

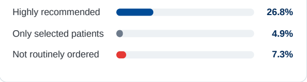

Clinical stance on baseline ApoE genetic testing before anti-amyloid therapy

THE INSIGHT

The data show how quickly safety information can reshape routine practice. Even though treatment may still be possible when genotype testing is not performed, most respondents want carrier status available before prescribing. That likely reflects the need to communicate risk more precisely rather than a belief that genotype alone determines treatment eligibility.

WHY IT MATTERS

Genetic testing adds time and complexity to the treatment pathway. The practical workflow must include consent for testing, interpretation, documentation, communication of what the result means for ARIA risk, and clarity about what it does not mean for the patient's broader genetic or family risk without appropriate counseling.



05

ARIA MANAGEMENT

When low-grade ARIA-E appears, most neurologists would stop and reassess rather than continue on schedule

73.2% would pause dosing, follow serial MRI until resolution, and cautiously re-challenge.

CONTEXT

ARIA turns treatment into a monitoring program. Both lecanemab and donanemab labels require baseline brain MRI and scheduled follow-up imaging, with additional evaluation when symptoms suggest ARIA. Management depends on symptoms and radiographic severity rather than on a single universal rule.

WHAT THE DATA SHOWS

Pausing and monitoring is selected by 73.2%. Continuing treatment on schedule with more frequent MRI is chosen by 14.6%, permanent discontinuation by 9.8%, and switching to another disease-modifying agent by 2.4%.

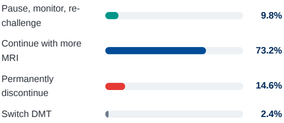
THE INSIGHT

Current U.S. prescribing information allows continued dosing for asymptomatic mild ARIA-E in some situations and recommends suspension as radiographic severity increases. Against that background, the survey response suggests a distinctly cautious real-world posture. The dominant choice prioritizes radiographic resolution and deliberate re-challenge even when symptoms are absent.

WHY IT MATTERS

This conservatism has operational consequences. Every interruption can create new imaging, scheduling, counseling, and re-initiation work. A neurology program therefore needs fast MRI access, reliable radiology turnaround, protocolized communication, and clear escalation pathways so that safety decisions do not become inconsistent or unnecessarily delayed.

Management of asymptomatic low-grade ARIA-E detected on surveillance MRI



06

PATIENT SELECTION

MCI is the center of gravity, but the hardest choices may be the patients who are biologically positive and clinically borderline

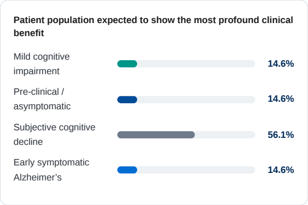
56.1% believe mild cognitive impairment is the population most likely to demonstrate the most profound clinical benefit.

CONTEXT

Lecanemab and donanemab are indicated for Alzheimer’s disease with treatment initiation in mild cognitive impairment or mild dementia, after confirmation of amyloid pathology. That makes early symptomatic disease the current treatment window. Blood biomarkers, however, make it increasingly possible to identify biological signals before functional impairment is pronounced.

WHAT THE DATA SHOWS

MCI leads at 56.1%. Pre-clinical or asymptomatic biomarker-positive patients, subjective cognitive decline, and early-stage symptomatic Alzheimer’s disease each receive 14.6%.



Patient population expected to show the most profound clinical benefit

THE INSIGHT

The structured data align with current labeled treatment stages, but the open-ended responses reveal the more difficult boundary cases. Neurologists describe uncertainty about biomarker-positive patients who have minimal clinical burden, how much benefit an individual is likely to experience, and how to weigh that benefit against ARIA risk, comorbidities, treatment burden, and access.

WHY IT MATTERS

The earlier the diagnosis moves, the more shared decision-making has to carry. A patient with MCI may still feel functionally independent and may be asked to accept repeated treatment and MRI monitoring for a benefit that is expressed as slowing decline rather than restoring lost function. That conversation requires time, calibrated expectations, and clarity about uncertainty.

07

POST-CLEARANCE STRATEGY

Amyloid clearance creates a new question: when should treatment stop, and what should trigger treatment again?

36.6% would stop therapy after complete plaque clearance but monitor serial blood biomarkers and retreat only if levels rise.

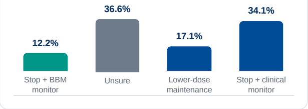
CONTEXT

Disease-modifying therapy introduces longitudinal decisions that were not part of traditional symptomatic Alzheimer’s treatment. Once amyloid burden falls, the clinician must decide whether to stop, maintain, monitor, or later restart therapy. Different anti-amyloid programs and labels are evolving toward different maintenance or stopping approaches.

WHAT THE DATA SHOWS

Biomarker-guided surveillance after stopping therapy leads at 36.6%. Uncertainty because of insufficient long-term post-clearance data is close behind at 34.1%. Lower-dose maintenance is selected by 17.1%, and stopping treatment with clinical monitoring alone by 12.2%.

Preferred strategy after complete amyloid plaque clearance



THE INSIGHT

The near tie between biomarker-guided surveillance and uncertainty shows why post-clearance management is a genuine evidence gap in practice. Lecanemab now includes maintenance options after the initial treatment period, while donanemab trials incorporated stopping based on amyloid PET thresholds. The question is not simply whether plaque can be removed, but how long the clinical value persists and which signal should trigger re-treatment.

WHY IT MATTERS

Blood biomarkers could eventually make longitudinal monitoring easier than repeated PET, but a biomarker rise is not automatically a validated retreatment threshold. Neurologists will need treatment-specific evidence that connects post-clearance biomarker behavior with renewed pathology, clinical risk, and benefit from restarting therapy.

08

PRIMARY-CARE SCREENING SCENARIO

Neurologists see promise in earlier detection, but they also expect referral volume to force a stricter gatekeeping model

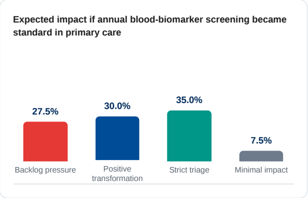
35.0% say hypothetical annual blood-biomarker screening in primary care would force neurology to adopt a triage model for specialist appointments.

CONTEXT

As blood tests become easier to order, it is tempting to imagine population-style screening. Current cleared tests do not support that leap: they are intended to aid diagnostic evaluation in people with cognitive impairment, and the Alzheimer's Association has emphasized a clinical plan for what happens after a positive result. The survey deliberately tests a future scenario to expose what widespread testing could do to neurology capacity.

WHAT THE DATA SHOWS

Strict specialist triage is the leading expectation at 35.0%. Positive transformation through earlier treatment is close behind at 30.0%. Another 27.5% expect a backlog of worried-well and false-positive referrals, while 7.5% believe primary care would manage most early positive results with minimal impact on neurology.


Expected impact if annual blood-biomarker screening became standard in primary care

THE INSIGHT

The split is not simply optimism versus pessimism. Both the positive and negative responses assume that referral volume could rise. The disagreement is whether the added volume would identify the right patients early enough to improve treatment opportunity or overwhelm a workforce already managing complex cognitive evaluations and treatment monitoring.

WHY IT MATTERS

A scalable early-detection model would need explicit triage criteria, validated cognitive assessment in primary care, guidance on which BBM results require specialist confirmation, and communication tools for indeterminate or discordant results. Without that architecture, better detection could create more uncertainty rather than more treatment-ready patients.

09

FUTURE READINESS

Lower ARIA risk matters more to neurologists than eliminating infusions, while overall sentiment remains cautiously optimistic

42.5% choose improved safety profiles of next-generation DMTs as the advance most critical to the early-intervention model.

CONTEXT

The current anti-amyloid pathway has several obvious targets for simplification: safer drugs, fewer infusions, more decisive blood tests, and faster MRI interpretation. The survey asks neurologists to choose which one would matter most, then separately asks how they feel about the treatment era as it exists today.

WHAT THE DATA SHOWS

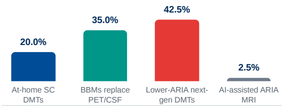
Improved safety with substantially lower ARIA risk leads at 42.5%. Blood biomarkers replacing PET and CSF are 35.0%, at-home subcutaneous DMTs 20.0%, and AI-assisted MRI grading 2.5%. On clinical sentiment, 52.5% are cautiously optimistic, 25.0% highly enthusiastic, 20.0% skeptical, and 2.5% unsupportive.

THE INSIGHT

The ordering explains the cautious optimism. Neurologists appear to accept that anti-amyloid therapy is an important step, but many want a better benefit-risk and delivery profile before it becomes easier to scale. Convenience alone does not resolve ARIA, patient-selection uncertainty, or the time required for shared decision-making.

WHY IT MATTERS

At-home treatment is already moving from aspiration toward reality. In 2026, the FDA approved a subcutaneous lecanemab starting regimen for home administration by patients or caregivers. That may reduce infusion burden, but the broader pathway still requires diagnostic confidence, risk stratification, imaging, monitoring, and access. The next major simplification may therefore come from making treatment intrinsically safer, not only easier to administer.



Advancement considered most critical over the next 3 to 5 years

OPEN-ENDED PERSPECTIVE

The hardest real-world problem is deciding what a positive biomarker should mean for this patient, in this health system, right now

The open-ended question asked neurologists for the single biggest real-world headache or clinical dilemma they face when managing early-stage MCI or pre-symptomatic Alzheimer’s patients. The source export displays 20 substantive responses. They are interpreted as qualitative themes rather than coded percentages.

Access can break the pathway after the decision is made

Respondents mention institutional support, insurance approval for scans and medication, reimbursement uncertainty, infusion logistics, therapy administration, and early PET or CSF access. These comments reinforce the structured finding that payer friction is the dominant operational bottleneck.

The biomarker can be positive before the clinical meaning feels settled

Neurologists describe difficult biomarker interpretation, questions about test accuracy or validation, and situations where a simple blood result is not enough to move a patient onto therapy. The tension is strongest when biological evidence is clearer than the patient’s current clinical burden.

Patient selection is a benefit-risk judgment, not a checkbox

Several responses focus on biomarker-positive patients with minimal symptoms, uncertainty about individual prognosis, comorbidities, treatment burden, ARIA risk, and whether a patient will meaningfully benefit. The comments add nuance to the strong MCI preference in the structured data.

Communication and monitoring remain clinical work

Respondents raise patient and family expectations, anxiety after a positive result, the desire for simpler treatment, efficient follow-up, and ARIA safety monitoring. Better biomarkers can reduce diagnostic uncertainty while simultaneously creating new counseling and surveillance responsibilities.

What the qualitative responses add: neurologists are not asking for a single technical fix. They are describing a pathway problem in which biomarker interpretation, treatment selection, safety, access, logistics, and patient communication all have to work together.

NEUROLOGY DECISION LENS

What a more workable early Alzheimer’s treatment pathway could look like

The survey does not prescribe a single protocol. It identifies the decision points where neurology services can reduce avoidable variation while preserving individualized judgment.

Define the positive-BBM handoff

Specify which patients should be referred, which clinical and cognitive information should accompany the result, and which test characteristics are acceptable for triage versus treatment confirmation.

Bundle treatment readiness

Coordinate amyloid confirmation, ApoE counseling, baseline MRI, medication and comorbidity review, payer authorization, and shared decision-making before scheduling the first dose.

Protocolize ARIA without removing judgment

Create treatment-specific rules for surveillance MRI, symptoms, radiographic severity, treatment interruption, re-challenge, and escalation so every ARIA finding does not start from zero.

Design the pathway beyond initiation

Plan for adherence, home administration where appropriate, plaque clearance, maintenance, biomarker follow-up, and possible retreatment so longitudinal care is not improvised after early treatment success.

PEOPLE ALSO ASK

Frequently asked questions about anti-amyloid therapy and Alzheimer’s blood biomarkers

What is anti-amyloid therapy for Alzheimer’s disease?

Anti-amyloid therapies are disease-modifying treatments designed to reduce amyloid beta plaques in the brain. Current approved therapies are used in the early symptomatic stages of Alzheimer’s disease after amyloid pathology has been confirmed and after individualized assessment of potential benefit and risk.

Can a blood test confirm Alzheimer’s disease without PET or CSF testing?

Some high-performing blood-based biomarker tests can support or, under specific evidence-based performance thresholds, substitute for amyloid PET or CSF testing in specialty care. Test performance and intended use matter, and results must be interpreted with the clinical picture rather than treated as universal stand-alone screening.

Why is ApoE testing important before anti-amyloid treatment?

ApoE ε4 status helps inform ARIA risk. FDA prescribing information for lecanemab and donanemab states that ApoE ε4 testing should be performed before treatment to inform risk, with counseling about the implications of genetic testing.

What is ARIA in Alzheimer’s treatment?

Amyloid-related imaging abnormalities, or ARIA, include edema or effusion and hemosiderin-related changes such as microhemorrhage or superficial siderosis. ARIA is often asymptomatic but can sometimes cause serious neurological complications, which is why baseline and follow-up MRI monitoring are part of anti-amyloid treatment pathways.

Which patients are considered for anti-amyloid therapy?

Current FDA labels for lecanemab and donanemab indicate treatment should be initiated in patients with mild cognitive impairment or mild dementia stage Alzheimer’s disease, with confirmed amyloid pathology. Individual eligibility also depends on safety factors, comorbidities, MRI findings, treatment burden, and shared decision-making.

Are blood-based biomarkers recommended for routine Alzheimer’s screening in asymptomatic adults?

Current cleared Alzheimer’s blood tests are intended to aid diagnostic evaluation in people with signs or symptoms of cognitive impairment, not as universal screening tests for asymptomatic adults. Broader screening strategies remain an evolving research and implementation question.

CLOSING PERSPECTIVE

The next breakthrough may be a treatment pathway that is as scalable as the diagnostic technology becoming available

This survey captures a field that has moved beyond the question of whether early biological diagnosis and anti-amyloid treatment belong in neurology. The harder question is whether the real-world system can turn those advances into consistent, safe, understandable care.

Blood-based biomarkers are already changing referrals, but the pattern is uneven. Some neurologists see positive blood-test referrals frequently, others only occasionally, and more than a quarter report that primary care in their network does not currently order the tests. This matters because the diagnostic technology is advancing faster than the referral architecture. A blood result can shorten the distance to amyloid detection, but only if the receiving service knows whether the result is a triage signal, a confirmatory signal, or a finding that still requires PET or CSF.

The confirmation data show that this transition is not finished. CSF remains the leading requirement, while a substantial group is ready to use a validated high-accuracy blood biomarker with clinical MRI without PET or CSF. Evidence-based guidance now provides performance thresholds that can help standardize that decision, but the implementation burden sits with real services choosing assays, defining workflows, and communicating what a result can and cannot establish.

Once treatment is considered, the pathway becomes even more demanding. Payer friction dominates the operational bottleneck, ahead of MRI access, workforce time, and infusion capacity. ApoE testing is treated as a core prescribing step by most respondents, and low-grade asymptomatic ARIA-E triggers a cautious pause-and-monitor strategy for nearly three quarters. These are not secondary administrative details. They determine whether a neurologist can safely move an eligible patient from diagnosis to treatment and keep that patient on therapy.

MCI is the clearest expected benefit window, consistent with the stages in which current approved therapies are initiated. Yet the open-ended responses make clear that the most difficult patients may sit around the edges of that window: biomarker-positive, minimally symptomatic individuals for whom prognosis, treatment burden, comorbidities, family expectations, access, and ARIA risk do not line up neatly. Earlier detection can therefore increase decision complexity even as it increases therapeutic opportunity.

The post-clearance data reveal another unfinished part of the model. The leading strategy is to stop therapy but continue blood-biomarker surveillance, while almost as many respondents remain unsure because long-term relapse and retreatment data are limited. That uncertainty will become more important as treatment regimens, home administration, and biomarker monitoring evolve. Starting therapy is only one point in a longitudinal disease-management pathway.

Neurologists' future priorities provide the clearest summary. Lower ARIA risk ranks above eliminating PET or CSF, home formulations, and AI-assisted MRI reading. Overall sentiment is cautiously optimistic rather than uniformly enthusiastic. That combination suggests the field is not rejecting anti-amyloid therapy. It is asking for a safer, clearer, more operationally coherent version of the model that already exists.

1 · Make referral criteria explicit

Define what a positive blood biomarker means at each performance level and what information primary care should provide before specialist review.

2 · Standardize confirmation rules

Use evidence-based test-performance thresholds to clarify when BBM triage, PET, CSF, or a validated substitute is appropriate.

3 · Treat access as a clinical pathway

Coordinate coverage, authorization, registry or documentation requirements, MRI, and treatment scheduling rather than handling them as separate administrative tasks.

4 · Build safety into the operating model

Combine ApoE counseling, baseline imaging, surveillance MRI, symptom response, and treatment-interruption protocols into treatment readiness.

5 · Protect shared decision-making time

Earlier-stage patients need realistic discussion of slowing decline, treatment burden, ARIA risk, uncertainty, and alternatives before treatment starts.

6 · Plan beyond plaque clearance

Define maintenance, monitoring, and potential retreatment strategies as evidence evolves so success does not create an unstructured follow-up phase.

Help future neurology insights reflect what happens after the biomarker turns positive.

Share your perspective with MDForLives and help build a clearer view of Alzheimer's diagnosis, anti-amyloid treatment, ARIA monitoring, patient selection, and access in real-world neurology practice.

Join the Panel

Sources used for this report

1. **MDForLives Neuro Insight Survey_Aug, SGID 8944880.** Source survey report: 55 survey records, 70.9% completion rate, six countries, and question-level values used exactly as reported. Administrative and validation fields were excluded. Open-ended themes were interpreted qualitatively without coding percentages.
2. **Alzheimer's Association.** Clinical Practice Guidelines & Evidence, including the 2025 guideline on blood-based biomarkers in specialty care.

https://www.alz.org/professionals/health-systems-medical-professionals/clinical-practice-guidelines-and-evidence

3. **Alzheimer's Association International Conference.** 2025 clinical practice guideline release on blood-based biomarkers, including performance-based recommendations for triage and confirmatory use in specialty care. https://aaic.alz.org/releases-2025/clinical-practice-guideline-blood-based-biomarkers.asp
4. **U.S. Food and Drug Administration.** FDA Clears First Blood Test Used in Diagnosing Alzheimer's Disease, May 16, 2025. The Lumipulse G pTau217/β-Amyloid 1-42 Plasma Ratio is intended to aid diagnosis in cognitively impaired patients and is not intended as a screening or stand-alone diagnostic test. https://www.fda.gov/news-events/press-announcements/fda-clears-first-blood-test-used-diagnosing-alzheimers-disease
5. **U.S. Food and Drug Administration.** Elecsys Phospho-Tau (217P) Plasma, 510(k) K261686, decision August 19, 2026. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K261686
6. **U.S. Food and Drug Administration.** LEQEMBI prescribing information, revised December 2025, including mild cognitive impairment or mild dementia initiation, amyloid confirmation, ApoE risk testing, MRI monitoring, and ARIA management. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761269s012s015lbl.pdf
7. **U.S. Food and Drug Administration.** KISUNLA prescribing information, revised July 2025, including mild cognitive impairment or mild dementia initiation, amyloid confirmation, ApoE risk testing, MRI monitoring, and ARIA management. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761248s004lbl.pdf
8. **Centers for Medicare & Medicaid Services.** Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease. Current CMS coverage-with-evidence-development and registry information. https://www.cms.gov/medicare/coverage/coverage-evidence-development/monoclonal-antibodies-directed-against-amyloid-treatment-alzheimers-disease-ad
9. **U.S. Food and Drug Administration.** FDA Approves First At-home Starting Dose for Alzheimer's Disease Treatment, 2026. The approval permits a subcutaneous lecanemab starting regimen administered at home by patients or caregivers. https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-first-home-starting-dose-alzheimers-disease-treatment

MDForLives

The Global Pulse of Healthcare

MDForLives is a global healthcare insights platform where healthcare professionals, patients, and caregivers discover, share, and shape the future of healthcare. This report presents aggregated perspectives for professional insight and discussion. It is not clinical guidance, treatment advice, or a substitute for patient-specific judgement, approved product information, or local practice standards.

© 2026 MDForLives
A Borderless Access platform
Real Opinions to Insights. Validated by Data.