

(aducanumab-avwa)

Date: \_\_\_\_\_

# ADUHELM infusion order

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone \_\_\_\_\_ M  F

DIAGNOSIS Please provide ICD-10 CODE \_\_\_\_\_

REFERRAL STATUS

Patient Weight: \_\_\_\_\_  kilo  lb

- New Prescription
- Order Renewal
- Does or Frequency Change
- Discontinuation

ALLERGIES \_\_\_\_\_

- Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
- MRI within 1 year attached
- Confirmed presence of amyloid pathology (CSF or PET scan) attached

Lab Orders: \_\_\_\_\_

## ADUHELM ORDERS

Administer Aduhelm IV every **4 weeks** as follows (SELECT ONE):

- Initial start w/ maintenance dosing:
  - 1mg/kg for infusion 1 and 2
  - 3mg/kg for infusion 3 and 4
  - 6mg/kg for infusion 5 and 6
  - 10 mg/kg for infusion 7 and beyond
- Other \_\_\_\_\_

Total dosage: \_\_\_\_\_

- Maintenance dosing only:
  - 10mg/kg
- Other \_\_\_\_\_

\*\* Once we receive all necessary documentation, we will schedule the patient's treatment

## PHYSICIAN INFORMATION

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contract Person: \_\_\_\_\_

## INSURANCE INFORMATION

Request prior authorization support  
(please send digital documentation)

Primary Insurance \_\_\_\_\_ Insurance company \_\_\_\_\_

Policy # \_\_\_\_\_

Policyholder's first and last name \_\_\_\_\_ Policyholder's DOB: \_\_\_\_\_ (MM/DD/YYYY)

Second Insurance \_\_\_\_\_ Policy #/ Group # \_\_\_\_\_