

(aducanumab-avwa)

ADUHELM

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

New Referral Referral Renewal Medication/Order Change Benefits Verification Only Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

- 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
- Maintenance dosing only:
- 10mg/kg
- Other _____
- Other _____

Other _____

Total dosage: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

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

NOTES/ADDITIONAL COMMENTS:

INSURANCE INFORMATION

Primary Insurance

Insurance company

Policy #

Policyholder's DOB:

Policyholder's first and last name

(MM/DD/YYYY)

Second Insurance

Policy #/ Group #