

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Manhattan**
57W 57Street
Suite 601
New York, NY 10019
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Manhattan**
225 East 70th Street
New York, NY 10021
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Bronx**
226 West 238th Street
Bronx, NY 10463
- Holbrook/Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

ADUHELM (aducanumab-avwa)

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 _____
- 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 #