☐ *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

ThrIVewell
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *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

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

(aducanumab-avwa)

ADUHELM infusion order

Date: _____

Mission Medical

Patient Name _____ **DOB** _____

Phone _____ **M☐ F☐**

DIAGNOSIS *Please provide ICD-10 CODE*

Patient Weight: _____ ☐kilo ☐lb

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

☐ Maintenance dosing only:
- 10mg/kg

** 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 priror authorization support (please sned digital documentation)

_____ _____
Primary Insurance Insurance company

_____
Policy #

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

_____ _____
Second Insurance Policy #/ Group #