

(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 DOB: _____

Policyholder's first and last name _____

(MM/DD/YYYY)

Second Insurance _____

Policy #/ Group # _____