

- 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



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Manhattan**
225 East 70th Street
New York, NY 10021
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- 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

(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 # _____