Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

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

REJUVEINATE

(aducanumab-avwa)

ADUHELM

Iinfusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐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

PATIENT WEIGHT

_____ lbs.

_____ kg

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:_____

** 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 #