



Aduhelm infusion orders

249 Danbury Rd, Wilton, CT 06897
 400 Columbus Ave, Valhalla, NY 10595
 127 Washington Ave, N. Haven, CT 06473
 220 Farmington Ave, Farmington, CT 06032

FAX: 203-724-4838

Patient Name _____ DOB _____
 Phone _____ Male _____ Female _____ Other _____
 Weight: _____ lbs (_____ kg) Height: _____ ft _____ in

Code	Description		Code	Description
G30.0	Alzheimer's disease, early onset	}	F02.80	Dementia without behavioral disturbance
G30.1	Alzheimer's disease, late onset		F02.81	Dementia with behavioral disturbance
G30.8	Other Alzheimer's disease			
G31.84	Mild cognitive impairment, so stated		Other	_____

ORDERS

	Treatment Number	Weight-based Dose
Loading Doses	Infusion 1 & 2	1 mg/kg
	Infusion 3 & 4	3 mg/kg
	Infusion 5 & 6	6 mg/kg
	Infusion 7 and beyond	10 mg/kg

Frequency: Every 4 weeks (at least 21 days apart)

Prescriber must indicate the following requirements have been met (please provide documentation):

Beta-amyloid pathology confirmed via:

Amyloid PET scan: Date: _____ **OR** CSF analysis: Date: _____ Result: _____

Cognitive assessment used: _____ Date: _____ Result: _____

MRI obtained prior to initiating Aduhelm therapy (within one year) Date: _____ Result: _____

Include documentation of early AD diagnosis/clinical notes for the diagnosis and any notes ruling out other conditions.

Referring provider to obtain MRI's prior to the 7th and 12th Infusion (must provide copy of image)

NOTES

ORDERING PROVIDER

Signature _____ Date _____

Provider _____ Phone _____ FAX _____