FAX: 203-724-4838

249 Danbury Rd, Wilton, CT 06897

400 Columbus Ave, Valhalla, NY 10595

127 Washington Ave, N. Haven, CT 06473

(aducanumab-avwa)

Aduhelm infusion orders

Patient Name ____ DOB____________

Phone ____________________ Male Female Other

Weight:__________lbs (__________kg) Height:__________ft ________in

DIAGNOSIS

Code	Description
G30.0	Alzheimer's disease, early onset
G30.1	Alzheimer's disease, late onset
G30.8	Other Alzheimer's disease
G31.84	Mild cognitive impairment, so stated

Code	Description
F02.80	Dementia without behavioral disturbance
F02.81	Dementia with behavioral disturbance

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 5th, 7th, 9th and 12th Infusion (must provide copy of image)

NOTES

ORDERING PROVIDER

Signature____Date______________________________

Provider____Phone______________FAX______________