

## PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Alzheimer's Disease  
 \_\_\_\_\_ Other: \_\_\_\_\_

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Including any applicable Labs/Tests/Imaging Studies and include confirmed presence of amyloid pathology 6. Baseline MRI (completed within the last year) - Note the PI recommends repeat MRIs prior to the 7th and 12th infusion

## Physician Information

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

## Medication Order

**Medication: ADUHELM® (aducanumab-avwa)** **New Start:**

Administer IV every 4 weeks as per below titration schedule to provide a total of 7 doses:

Infusion 1 & 2	1 mg/kg
Infusion 3 & 4	3 mg/kg
Infusion 5 & 6	6 mg/kg
Infusion 7	10 mg/kg

 **Maintenance Regimen:**

Administer 10 mg/kg (\_\_\_\_\_ mg) IV every 4 weeks

\_\_\_\_\_ # Refills (Recommend 11 Refills)

**Pre-Medication Orders:** No Pre-Meds recommended

\_\_\_\_\_ Option to order Pre-meds

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
Physician's NPI#

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date