AYSA

THERAPEUTICS INFUSION CENTER

ADUHELM (ADUCANUMAB-AVWA) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: __________ Phone: ______________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ______________________________ ICD-10 Code: __________

Patient Weight: __________ lbs.

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

Cognitive Assessment Date: ________ Name of Assessment: ____________ Score: ________

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

☐ Maintenance dosing only:

- 10mg/kg

** Once we receive all necessary documentation, we will schedule the patient's treatment

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ________________ Physician Name: ________________ Date: ________
Phone: ______________ Fax: ______________ Contact Person: ________________

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