# ADUHELM (ADUCANUMAB-AVWA) Order Form

**PHONE** 515.225.2930 | **FAX** 515.559.2495

## Patient Information

☐ **Demographics Attached**

**Patient Name:** _____ **DOB:** _____ **Phone:** _____

**INSURANCE INFORMATION:** Please attach a copy of prescription/medical card(s) (front and back).

## Medical Information

**Diagnosis:** _____ **ICD-10 Code:** _____

**Patient Weight:** _____ lbs. (required) **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:
- 1 mg/kg for infusions 1 and 2
- 3 mg/kg for infusions 3 and 4
- 6 mg/kg for infusions 5 and 6
- 10 mg/kg for infusions 7 and beyond

☐ Maintenance dosing only:
- 10 mg/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 *Hy-Vee Health* 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:** _____

## Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM