



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 _____

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