

ADUHELM (ADUCANUMAB-AVWA)

Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information				Demograp	phics Attached	
Patient Name:		D	OB:	Phone:		
INSURANCE INFORMATION: Please attach a copy of prescription/medical card(s) (front and back).						
Medical Information						
Diagnosis:		ICD-	10 Code:			
Patient Weight:	os. (required) Al	lergies:				
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:	Na	me of Assessment:		So	core:	
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						
Additional orders, comments						
Physician Information						
By signing this form and utilizing our services, you are authorizing <i>Hy-Vee Health</i> 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:	Physician Name:		Date:	
Phone: F	ax:	Contact Person:				
Service Areas						
Des Moines, IA West	t Des Moines, IA	Chicago, IL	Omaha, NE	Buffalo, NY	Dallas, TX	
Phoenix, AZ Other		-				

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