Hy-Vee health INFUSION CARE

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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