MRN:_____

DOB:_____

Standard Aduhelm® (aducanumab-avwa) Plan of Treatment

NOTE: We require MD office notes to support clinical treatment and may require a Letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patient Medicare and/or other insurance plan.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: Please select the appropriate G **and** F codes:

- ☐ G30.0 Alzheimer's disease with early onset
- ☐ G31.84 Mild Cognitive Impairment, so stated
- ☐ G30.1 Alzheimer's disease with late onset
- ☐ G30.8 Other Alzheimer's Disease
- ☐ F02.81 Dementia with behavior disturbance
- ☐ F02.80 Dementia without behavior disturbance
- ☐ Other ICD 10 Code/Diagnosis: _____

4. Pre-medications: ***Administered 30 minutes prior to infusion as selected:***

Acetaminophen:
- □ 1000 mgs PO
- □ 650mgs PO
- □ 500mgs PO
- □ 325mgs PO

Diphenhydramine: □ 25 mgs PO, □ 50mgs PO, □ 25 mgs IVP, □ 50mgs IVP or

Alternate oral antihistamine to diphenhydramine: □ Cetirizine 10 mg,

□ Loratadine 10 mg, Fexofenadine □ 60mgs or □ 180mgs

Methylprednisolone □ 40mgs IVP □ 125mgs IVP or other_____mgs IVP

Pre-medicate with other: _____

5. Dose: Aduhelm ® (aducanumab-avwa) over approximately one hour every 4 weeks and at least 21 days apart as directed to infuse per protocol via pump with 0.2 or 0.22-micron filter.

☐ **Initial titration dosing:** Aduhelm ® (aducanumab-avwa) according to dosing table below followed by maintenance dose of Aduhelm ® (aducanumab-avwa) 10mg/kg every 4 weeks (at least 21 days apart):

IV Infusion (every 4 weeks)	Aduhelm ® Dosage (administer over approximately one hour)
Infusion 1 and 2	**1mg/kg**
Infusion 3 and 4	**3mg/kg**
Infusion 5 and 6	**6mg/kg**
Infusion 7 and beyond	**10mg/kg**

☐ **Maintenance Dosing**: Aduhelm ® (aducanumab-avwa) is 10mg/kg in 100ml of 0.9% Sodium Chloride every 4 weeks (at least 21 days apart)

Monitoring: Referring provider to obtain MRIs prior to the 7th infusion (first dose of 10mg/kg) and 12th infusion (sixth dose of 10mg/kg).

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

MRN:_____

DOB:_____

Guidelines for Prescribing Aduhelm® (aducanumab-avwa) Plan of Treatment

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*

(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

☐ Include recent (within one year) brain magnetic resonance imaging (MRI).

☐ Include primary caregiver contact information, authorization to release protected health information, and/or POA if applicable.

Name:_____ Phone:_____Relationship: _____

☐ Diagnostic test confirming the presence of amyloid plaque build up

☐ Other as requested: _____

WARNINGS AND PRECAUTIONS. Amyloid Related Imaging Abnormalities. ADUHELM can cause amyloid related imaging abnormalities-edema (ARIA-E), which can be observed on MRI as brain edema or sulcal effusions, and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis. Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment. The safety of ADUHELM® in patients with any pre-treatment localized superficial siderosis, 10 or more brain microhemorrhages, and/or with a brain hemorrhage greater than 1 cm within one year of treatment initiation has not been established**.** **Hypersensitivity Reactions**. Promptly discontinue the infusion upon the first observation of any signs or symptoms consistent with a hypersensitivity

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.