ID Infusion Center
CONSULTANTS INC

ADUHELM (aducanumab-avwa)

FAX TO (216) 378-9824
FOR QUESTIONS, CALL (216) 360-0456

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Allergies: _____ Ht (in): _____ Wt (kg): _____ Gender: M | F

Demographic Information Attached: ☐ Yes

Insurance Information Attached (front and back of card): ☐ Yes

Infusion location: ☐ Beachwood ☐ Painesville ☐ Fairlawn ☐ Westlake ☐ Middleburg Heights ☐ Youngstown

Patient Status:
- ☐ New to Therapy
- ☐ Order Renewal
- ☐ Change of Dose | Frequency
- ☐ Continuing Treatment | Transfer from a Prior Site of Care. Next Treatment Due Date: _____

(Efforts will be taken to maintain treatment schedules, but next due date cannot be guaranteed)

2 CLINICAL INFORMATION

ICD-10 Code (required): _____ ICD-10 Description: _____

- ☐ Clinical/Progress Notes, Labs, Tests Supporting Primary Diagnosis Attached
- ☐ MRI Within 1 Year Attached
- ☐ Confirmed Presence of Amyloid Pathology (CSF or PET Scan) Attached

*** Per Aduhelm label, obtain MRI before 7th and 12th infusion.

3 INFUSION ORDER

Aduhelm: Administer Aduhelm IV every 4 Weeks as Follows:

☐ Initial Start with Maintenance Dosing
- 1 mg/kg for infusion 1 and 2
- 3 mg/kg for infusion 3 and 4
- 6 mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

☐ Maintenance Dosing Only
- 10 mg/kg

Comments/Special Considerations: _____

LAB REQUIREMENTS & LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBER. INFUSION ORDERS ARE VALID FOR ONE YEAR (UNLESS OTHERWISE SPECIFIED). INFUSIONS WILL BE ADMINISTERED PER ID CONSULTANTS INFUSION CENTER POLICY AND PROTOCOLS.

4 PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____

FOR MORE INFORMATION OR TO ACCESS REFERRAL FORMS, VISIT OUR WEBSITE AT WWW.IDCONSULTANTS.COM/ORDER_FORMS