Phone: 616-954-0600 Fax: 616-954-1675

Aduhelm IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Please attach the following:
PET scan or CSF results with amyloid beta confirmation
Recent MRI of brain (within past year)
Results of cognitive assessment
Letter of medical necessity

Aduhelm (aducanumab-avwa) IV

☐ **Initial Dosing:**
Infusion 1 & 2: **1 mg/kg**
Infusion 3 & 4: **3 mg/kg**
Infusion 5 & 6: **6 mg/kg**
Infusion 7 and beyond: **10 mg/kg**

☐ **Maintenance Dosing: 10 mg/kg**

Frequency: EVERY 4wks

Repeat MRI's **MUST be obtained prior to infusion 7 and infusion 12**

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____