MIC | METRO INFUSION CENTER

INFUSION ORDERS - ADUHELM® (ADUCANUMAB-AVWA)

REFERRAL STATUS

- ☐ New Referral
- ☐ Dose or Frequency Change
- ☐ Order Renewal Change

PATIENT INFORMATION

Name: _____ Date of Referral: _____

Height: _____ Weight: _____ DOB: _____

Allergies: _____

DIAGNOSIS AND ICD 10 CODE

Primary Code

- ☐ G30.0 Alzheimer's Disease, early onset
- ☐ G30.1 Alzheimer's disease, late onset
- ☐ G30.8 Other Alzheimer's disease
- ☐ G31.84 Mild cognitive Impairment, so stated
- ☐ Other: ICD Code _____ Description: _____

Secondary Code* Required

- ☐ F02.80 Dementia without behavior disturbance
- ☐ F02.81 Dementia with behavior disturbance

PRESCRIBER MUST INDICATE THE FOLLOWING REQUIREMENTS HAVE BEEN MET (PLEASE PROVIDE DOCUMENTATION):

☐ Beta-amyloid pathology confirmed via:

☐ Amyloid PET scan Date: _____ OR ☐ CSF analysis Date: _____ Result: _____

☐ Cognitive assessment used: _____ Date: _____ Result: _____

☐ MRI obtained prior to initiating Aduhelm therapy (within one year) Date: _____ Result: _____

PRE-INFUSION

☐ Measure and record weight prior to each treartment

☐ Hold Infusion and notify provider if patient reports:

- headache
- dizziness
- nausea
- vision changes
- new or worsening confusion

☐ Calculate aducanumab-avwa dose using patient's actual weight and dose table below. Do not round dose.

☐ Dilute required volume of aducanumab-avwa in 100 ml 0.9% sodium chloride and infuse over at least 60 minutes using a sterile, low protein-binding 0.2- or 0.22-micron in-line filter.

TREATMENT	WEIGHT-BASED DOSE
Infusion 1 and Infusion 2	1 mg/kg
Infusion 3 and Infusion 4	3 mg/kg
Infusion 5 and Infusion 6	6 mg/kg
Infusion 7 and beyond	10 mg/kg

☐ If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

☐ Schedule treatments every 4 weeks (at least 21 days apart). Order valid for one year unless otherwise indicated:

- ☐ Order expires on: _____
- ☐ Order expires after: _____ treatments

REQUIRED DOCUMENTATION

- ☐ This signed order form by the provider
- ☐ Patient demographics & insurance information
- ☐ Include signed and completed Plan of Treatment
- ☐ Include any lab results and/or tests to support diagnosis
- ☐ Include recent (within 1 year) brain magnetic resonance imaging (MRI)
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy

PHYSICIAN INFORMATION

Prescribing Physician: _____

Office Phone: _____ Office Fax: _____

Physician email: _____

Physician signature: _____

Contact us with questions at:
BioNurses@MetroInfusionCenter.com or (877) 448-3627
Fax completed form and all documentation to (866) 507-1164

All informantion contained in this form is strictly confidential and will become part of the patient's medical record.