Provider Order Form

ADUHELM (ADUCANUMAB-AVWA)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Alzheimer's Disease with Early Onset G30. _____ ☐ Dementia without Behavioral Disturbance F20. _____

☐ Other: _____ ☐ Mild Cognitive Impairment G31.84

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Aduhelm (Aducanumab-Avwa), IV in 0.9% sodium chloride, intravenous infusion	☐ 1mg/kg	☐ Infusion 1: 1 mg/kg
		☐ Infusion 2: 1 mg/kg 4 weeks after Infusion 1
	☐ 3 mg/kg	☐ Infusion 3: 3 mg/kg 4 weeks after Infusion 2
		☐ Infusion 4: 3 mg/kg 4 weeks after Infusion 3
	☐ 6 mg/kg	☐ Infusion 5: 6 mg/kg 4 weeks after Infusion 4
		☐ Infusion 6: 6 mg/kg 4 weeks after Infusion 5
	☐ 10 mg/kg	☐ Maintenance Dose: 10 mg/kg every 4 weeks after Infusion 6

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ MRI- Prior to initiating treatment (within 1 year)

_____ _____

Provider Signature Date