

## ADUHELM MEDICATION ORDER

Patient's Name (Last, First, Middle) \_\_\_\_\_ DOB: \_\_\_\_\_

### ■ Diagnosis

G31.84 Mild cognitive impairment, so stated

OR

G30.0 Alzheimer's disease with early onset

G30.1 Alzheimer's disease with late onset

G30.8 Other Alzheimer's disease

AND EITHER OF →

F02.80 Dementia without behavioral disturbance

F02.81 Dementia with behavioral disturbance

### ■ Details Needed for Authorization

- MRI from within the past year.
- CSF results or PET scan showing confirmed presence of amyloid pathology.
- Please include cognitive assessment report. Also include Date: \_\_\_\_\_ Assessment name: \_\_\_\_\_ Score: \_\_\_\_\_
- What is the state of the patient's cognitive impairment? Circle one: Mild Moderate Severe Other: \_\_\_\_\_
- Documentation of your differential diagnoses and substantiation of dismissal of alternate diagnoses.

### ■ Aduhelm (aducanumab-avwa) Medication Order

Patient's height in ft/in: \_\_\_\_\_ Patient's weight in lbs: \_\_\_\_\_

Select all doses required.

Initial dosing, administered every 4 weeks:

- Infusions 1 & 2: 1 mg/kg
- Infusions 3 & 4: 3 mg/kg

- Infusions 5 & 6: 6 mg/kg
- Infusions 7 & 8: 10 mg/kg

Maintenance dosing: 10 mg/kg every 4 weeks for a period of \_\_\_\_\_ months.

Medication shall be added to a 100ml 0.9% NaCl infusion bag. The IV line shall have a 0.2 or 0.22 micron in-line filter attached. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

### ■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

### ■ Ordering Provider Authorization

Provider's Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI #: \_\_\_\_\_ License: \_\_\_\_\_

### STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

**Fax this order and supporting documentation to (732) 329-2322.**