Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

ADUHELM MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ **Diagnosis** *Please select both a G code and an F code.*

☐ G31.84 Mild cognitive impairment, so stated

☐ G30.0 Alzheimer's with early onset (at <65y/o)
☐ G30.1 Alzheimer's with late onset (at ≥65y/o)
☐ 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: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

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.