TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

ADUHELM ORDER FORM

Date:

Patient Name:

Date of Birth:

Allergies: _____

Weight: _____lbs OR _____kg

Diagnosis	Provider Information
☐ G31.84 Mild Cognitive Impairment ☐ G30.0 Alzheimer's disease, early onset-☐ _____ ☐ G30.1 Alzheimer's disease, late onset--☐ _____ ☐ G30.8 Other Alzheimer's disease-☐ _____ *G30.X codes require a secondary F02.8X code; Please write in above*	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER (NOTE: ONLY ONE STAGE OF TREATMENT MAY BE ORDERED AT A TIME)

☐ STAGE 1 (Infusions #1-6)

✓ Aduhelm 1mg/kg IV q4 weeks x two doses per protocol

✓ Aduhelm 3mg/kg IV q4 weeks x two doses per protocol

✓ Aduhelm 6mg/kg IV q4 weeks x two doses per protocol

Required Documentation to initiate this phase:

✓ MRI of brain within one year prior to first infusion.

✓ Date of MRI: _____

☐ By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET

☐ STAGE 2 (Infusions #7-11)

✓ Aduhelm 10mg/kg IV q4 weeks per protocol x five doses.

Required Documentation to initiate this phase:

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #7. I have reviewed the results and clear patient to proceed with infusion #7 through #11.

☐ STAGE 3 (Infusions #12 +)

✓ Maintenance Dosing: Aduhelm 10mg/kg IV q4 weeks per protocol.

☐ Refills: _____

Required Documentation to initiate this phase:

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #12. I have reviewed the results and clear the patient to proceed with maintenance infusions.

LAB ORDERS (Please indicate any labs to be drawn and frequency)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____

Prescriber Name Date

Substitution Allowed:

_____ _____

Prescriber Name Date

V 3.24.22