TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

ADUHELM ORDER FORM

Date: _____ Patient Name: _____ Date of Birth: _____

Alergies: _____ Weight: _____ lbs OR _____ kg

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

DIAGNOSIS

- ☐ 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 secondaryF02.8X code; Please write in above ****

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

☐ **Stage 1** (Infusions #1-4)	☐ **Stage 2** (Infusions #5-6)	☐ **Stage 3** (Infusions #7-8)	☐ **Stage 4** (Infusions #9-11)	☐ **Stage 5** (Infusions #12+)
✓ 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	✓ Aduhelm 10mg/kg IV q4 weeks per protocol x two doses	✓ Aduhelm 10mg/kg IV q4 weeks per protocol x three doses	✓ Maintenance Dosing: Aduhelm 10mg/kg IV q4 weeks per protocol. ☐ Refills: _____
Required Documentation to initiate this phase:	**Required Documentation to initiate this phase:**	**Required Documentation to initiate this phase:**	**Required Documentation to initiate this phase:**	**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 has been confirmed via CSF or PET	☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #5. I have reviewed the results and clear patient to proceed with infusion #5 through #6	☐ 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 #8	☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #9. I have reviewed the results and clear patient to proceed with infusion #9 through #11	☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #12. I have reviewed the results and clear 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 the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____

Prescriber Name Date

Substitution Allowed:

_____ _____

Prescriber Name Date