OKLAHOMA INFUSION SERVICES

# Aduhelm Order Form

**Please fax form to: 405-726-9849**

## Patient Information

| Patient Name: | DOB: | Phone: | Gender: M ☐ F ☐ |
|---|---|---|---|
| Patient Address: | Email: | Insurance: | |

## Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax Amyloid Beta Confirmation

## Diagnosis and Clinical Information

**Diagnosis (ICD-10):**

☐ G30.0 Alzheimer's Disease with Early Onset **OR** ☐ G30.1 Alzheimer's Disease with Late Onset **OR** ☐ G30.8 Other Alzheimer's Disease
**+ Either** ☐ F02.80 Dementia without Behavioral Disturbance **OR** ☐ F02.81 Dementia with Behavioral Disturbance
☐ G31.84 Mild Cognitive Impairment, so Stated
☐ Other: Code: _____ Description: _____

**Clinical Information:**

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ Name of Cognitive Assessment Used: _____ Assessment Date: _____ Assessment Score: _____
☐ Last Brain MRI: Date: _____ ☐ Last Brain MRI within one year of initiating Aduhelm treatment? ☐ Yes ☐ No
☐ Does patient have history of life threatening reaction to Aduhelm? ☐ Yes ☐ No

## Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐
☐ Other: _____

## Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

## Prescription Information

☐ Aduhelm

☐ Infusion 1: 1mg/kg
☐ Infusion 2: 1mg/kg 4 weeks after Infusion 1
☐ Infusion 3: 3mg/kg 4 weeks after Infusion 2
☐ Infusion 4: 3mg/kg 4 weeks after Infusion 3
☐ Infusion 5: 6mg/kg 4 weeks after Infusion 4
☐ Infusion 6: 6mg/kg 4 weeks after Infusion 5
☐ Maintenance Dose: 10mg/kg every 4 weeks after Infusion 6

*Note: MRI's must be obtained prior to Infusion 7 and Infusion 12.*

## Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP ☒ Benadryl 25mg PO PRN
☒ Tylenol tablet 500-1000mg PO PRN ☐ Other: _____

## Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

## Prescriber Information

| Prescriber Name: | | Office Contact Name: | |
|---|---|---|---|
| NPI #: | DEA #: | Contact Phone: | Contact Fax: |

_____ _____
**Prescriber's Signature:** **Date:**

*By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.*

**Please fax form to: 405-726-9849**