INTRAMED Plus
infusion services

ADUHELM®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Alzheimer's Disease ICD-10 Code: G30._____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Including any applicable Labs/Tests/Imaging Studies
  - Include confirmed presence of amyloid pathology
- Baseline MRI (completed within the last year)
  - Note the PI recommends repeat MRIs prior to the 7th and 12th infusion
- Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

ADUHELM® (aducanumab-avwa) J Code: J_____

4. Drug Order:

❑ **New Start:**
Administer IV every 4 weeks as per below titration schedule to provide a total of 7 doses:

Infusion 1 & 2	1 mg/kg
Infusion 3 & 4	3 mg/kg
Infusion 5 & 6	6 mg/kg
Infusion 7	10 mg/kg

❑ **Maintenance Regimen:**
Administer 10 mg/kg (_____ mg) IV every 4 weeks _____ # Refills (Recommend 11 Refills)

Pre-Medication Orders: No Pre-Meds recommended

_____
Option to order Pre-meds

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____ Contact Phone #: _____

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754
ALTERNATE FAX 803.999.1887

INFUSION CENTER LOCATIONS
COLUMBIA CHARLESTON GREENVILLE
CENTRAL INTAKE PHONE 800.767.6337