Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Alzheimer's Disease with Early Onset	ICD 10 Code: G30.0
☐ Alzheimer's Disease with Late Onset	ICD 10 Code: G30.1
☐ Other Alzheimer's Disease	ICD 10 Code: G30.8
+ EITHER ☐ Dementia without Behavioral Disturbance	ICD 10 Code: F02.80
OR ☐ Dementia with Behavioral Disturbance	ICD 10 Code: F02.81
☐ Mild Cognitive Impairment, so Stated	ICD 10 Code: G31.84
☐ Other _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis
☐ Amyloid Beta Confirmation

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation - treatment start date: _____

Last Brain MRI: Date: _____

List Tried & Failed Therapies, including duration of treatment:
1) _____
2) _____

Name of Cognitive Assessment Used:
Assessment Date: _____ Assessment Score: _____

Does patient have a history of life threatening reaction to Aduhelm? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

☐ J0172 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 5, 7, 9 and 12.

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

☐ Acetaminophen 500 mg PO PRN
☐ Benadryl 25 mg PO or IV
☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - ADUHELM

Clinics Scan to: Physician Orders