ADUHELM
(aducanumab)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- MRI within 1 year
- CSF or PET scan showing amyloid pathology
- Cognitive assessment & score

- Is MD enrolled in Biogen PATH program? ☐ Y ☐ N
- Is patient enrolled in Biogen PATH program? ☐ Y ☐ N

PRIMARY DIAGNOSIS

☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.9 Alzheimer's disease, unspecified
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Aduhelm
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Aduhelm IV every 4 weeks as follows:
- 1 mg/kg for infusion 1 and 2
- 3 mg/kg for infusion 3 and 4
- 6 mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

☐ Other:_____

☑ MRI to be obtained by referring provider prior to infusions 5, 7, 9, and 12.

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ Provider Signature

_____ Date