FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

(aducanumab-avwa)

Date: _____

ADUHELM infusion order

Patient Name _____ DOB _____

Phone _____ M☐ F☐

DIAGNOSIS *Please provide ICD-10 CODE*

Patient Weight: _____ ☐kilo ☐lb

ALLERGIES _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ MRI within 1 year attached

☐ Confirmed presence of amyloid pathology (CSF or PET scan) attached

Lab Orders: _____

ADUHELM ORDERS

Administer Aduhelm IV every **4 weeks** as follows (SELECT ONE):

☐ Initial start w/ maintenance dosing:
- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

☐ Maintenance dosing only:
- 10mg/kg

** Once we receive all necessary documentation, we will schedule the patient's treatment

PHYSICIAN INFORMATION

Signature: _____ Date: _____

Name: _____

Phone: _____ Fax: _____ Contract Person: _____

INSURANCE INFORMATION

☐ Request priror authorization support (please sned digital documentation)

_____ _____
Primary Insurance Insurance company

_____
Policy #

_____ Policyholder's DOB: _____
Policyholder's first and last name (MM/DD/YYYY)

_____ _____
Second Insurance Policy #/ Group #