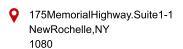


Policy #

Second Insurance

Policyholder's first and last name



C	914-460-489
$\checkmark$	fuse@fuseinfusion.com

<b>✓</b>	fuse@fuseinfusion.cor
<b>=</b> .	914-460-4571

## (aducanumab-avwa)

Date: \_\_\_\_\_

ok the switch to biosimilar if insurance formulary prefers

ADU	HELI <b>VI</b> in	fusion order
Patient Name _	DOB	
Phone		M□ F□
DIAGNOSIS Ple	ease provide ICD-10 CODE	
Patient Weight:	□ kilo □	] <b>lb</b>
ALLERGIES _		
MRI within 1 yea		oporting primary diagnosis attached  CSF or PET scan) attached
ADUHELM OI	RDERS	
☐ Initial start w • 1 mg • 3 mg • 6 mg • 10 n	elm IV every <b>4 weeks</b> as fo / maintenance dosing: /kg for infusion 1 and 2 /kg for infusion 3 and 4 /kg for infusion 5 and 6 ng/kg for infusion 7 and be e dosing only: g/kg	
** Once we receive	e all necessary documentation	n, we will schedule the patient's treatment
PHYSICIAN IN	IFORMATION	
		Date:
Phone:	Fax:	Contract Person:
	NFORMATION	Request priror authorization support (please sned digital documentation)
Primary Insurance		Insurance company

Policyholder's DOB:

(MM/DD/YYYY)

Policy #/ Group #