Patient Name:

DOB:

Aducanumab-avwa (Aduhelm™) Infusion Orders

① Diagnosis:
- ☐ G30.0 Alzheimer's disease, early onset
- ☐ G30.1 Alzheimer's disease, late onset   ← G30.X codes require
- ☐ G30.8 Other Alzheimer's disease   secondary F02.8X code →
- ☐ G31.84 Mild cognitive impairment, so stated

- ☐ F02.80 Dementia without behavioral disturbance
- ☐ F02.81 Dementia with behavioral disturbance

☐ Other: _____ _____
  (ICD-10 code)   (description)

Gender: ☐ M ☐ F	**Height:**	☐ CM ☐ IN	**Weight:**	☐ KG ☐ LB

Prescriber must indicate the following requirements have been met (please provide documentation):

② ☐ Beta-amyloid pathology confirmed via:
  ☐ Amyloid PET scan Date: _____   **OR**   ☐ CSF analysis Date: _____ Result: _____

③ ☐ Cognitive assessment used: _____ Date: _____ Result: _____

④ ☐ MRI obtained prior to initiating Aduhelm therapy (within one year) Date: _____ Result: _____

Pre-Infusion:
- ☑ Measure and record weight prior to each treatment to determine dose.
- ☑ Hold infusion and notify provider if patient reports:
  - ▪ headache
  - ▪ dizziness
  - ▪ nausea
  - ▪ vision changes
  - ▪ new or worsening confusion

☑ Calculate aducanumab-avwa dose using patient's actual weight and dose table below. Do not round dose.

☑ Dilute required volume of aducanumab-avwa in 100 ml 0.9% sodium chloride and infuse over at least 60 minutes using a sterile, low protein-binding 0.2- or 0.22-micron in-line filter.

Treatment Number	Weight-based Dose
Infusion 1 and Infusion 2	1 mg/kg
Infusion 3 and Infusion 4	3 mg/kg
Infusion 5 and Infusion 6	6 mg/kg
Infusion 7 and beyond	10 mg/kg

☑ If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

☑ Schedule treatments every 4 weeks (at least 21 days apart). Order valid for one year unless otherwise indicated:

☐ Order expires on _____   ☐ Order expires after _____ treatments

Post-Infusion:
- ☑ Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.
- ☑ Fax treatment notes to provider at number below

Prescriber name (print): _____ Fax: _____

Prescriber signature: _____ Date: _____