Aducanumab (ADUHELM™) Referral Form

Please complete the following form and send to the Alzheimer's Disease Therapeutic Care Management Center:

FAX: 844-276-1706
EMAIL BOX: aduhelm@soleohealth.com
PHONE: 844-960-9090

Referral Process

1. **PATIENT INFORMATION** (*indicates a required field)	2. **PHYSICIAN INFORMATION** (*indicates a required field)
Name*: ______________________	Physician's name*: ______________________
Address*: ______________________	License #: __________ NPI #*: __________
City*: __________ State*: _____ Zip*: _____	DEA #: __________ Email*: __________
Home Phone: __________ Mobile Phone*: __________	Address*: ______________________
Email*: ______________________ Primary language*: ______________________	City*: ______________________ State*: _____ Zip*: __________
DOB*: __________ Social Security #*: __________	Office Contact: ______________________
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: __________ Fax*: __________ Specialty*: __________

Allergies*: ______________________ NKA*: ☐
Alternate contact name: __________ Alternate contact phone: __________
☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. **DIAGNOSIS*** (*indicates a required field) Year of diagnosis: __________
☐ G30.0: Alzheimer's disease with early onset **plus either** ☐ F02.80 Dementia *without* behavioral disturbance ***OR*** ☐ F02.81 Dementia *with* behavioral disturbance
☐ G30.1: Alzheimer's disease with late onset **plus either** ☐ F02.80 Dementia *without* behavioral disturbance ***OR*** ☐ F02.81 Dementia *with* behavioral disturbance
☐ G30.8: Other Alzheimer's disease **plus either** ☐ F02.80 Dementia *without* behavioral disturbance ***OR*** ☐ F02.81 Dementia *with* behavioral disturbance
☐ G31.84 Mild cognitive impairment, so stated
☐ Other diagnosis(es): ______________________

4. **Please submit the following documents with this referral form:**

- Completed, dated and signed Biogen Support Services Request Form *if assistance requested by patient*
- Copy of the front and back of health insurance card
- Demographics sheet
- Current weight
- History and physical
- Results of MRI within past year
- Three most recent office visit notes
- If available and not included in the history and physical or visit notes, please include:
  - PET scan or CSF lab results with Aβ confirmation
  - Results of cognitive assessment
  - Diagnosis date
- Medication list
- Most recent laboratory results

5. **PRESCRIPTION INFORMATION** Anticipated Start Date: ______________

Prescription*: Aducanumab (ADUHELM™) 170 mg/1.7 mL (100 mg/mL) solution in a single-dose vial ***OR*** 300 mg/3 mL (100 mg/mL) solution in a single-dose vial. Dilution in 100 mL of 0.9% Sodium Chloride Injection, USP, is required prior to administration

☐ Administer ADUHELM™ doses IV as follows every 4 weeks:

IV Infusion (every 4 weeks)	ADUHELM Dosage (administered over approximately one hour, through an intravenous line with a low protein binding 0.2 or 0.22 micron in-line filter)
Infusion 1 and 2	1 mg/kg
Infusion 3 and 4	3 mg/kg
Infusion 5 and 6	6 mg/kg
Infusion 7 and beyond	10 mg/kg

Additional orders: _____
Access: ☐ Peripheral Other: _____

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 mL NS, followed by Heparin 2-5 mL 10 units/mL if indicated

Port: Flush before, after each infusion, and as needed with 5-20 mL NS, followed by Heparin 100 unit/ml 5 mL.

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

☐ Other: ________________________

Skilled Nursing Services Needed? ☐ Yes ☐ No Additional Instructions: ______________________________________

8.

PHYSICIAN'S SIGNATURE (required): ____ **Date:** __________________

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.