Aducanumab (ADUHELM™) Referral Form

Please complete the following form and send to the Soleo Health 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)

Name*: _____
Address*: _____
City*: _____ State*: _____ Zip*: _____
Home Phone: _____ Mobile Phone*: _____
Email*: _____
Primary language*: _____
DOB*: _____ Social Security #*: _____
Gender*: ☐ M ☐ F Height: _____ Weight*: _____

2. PHYSICIAN INFORMATION (*indicates a required field)

Physician's name*: _____
License #: _____ NPI #*: _____
DEA #: _____ Email*: _____
Address*: _____
City*: _____ State*: _____
Zip*: _____
Office Contact: _____
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.