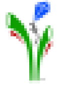

Allergy, Asthma & Immunology Center, P.C.
Infusion Services

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

ADUHELM™ (aducanumab-avwa) ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ New Referral   _____ Order Renewal   _____ Medication/Order Change
_____ Benefits Verification Only   _____ Discontinuation Order

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

ADUHELM ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10 PRIMARY*: ______________________________

ICD -10 Secondary*: ______________________________

____ Initial Dose (every 4 weeks)
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)

____ Maintenance Dose of 10mg/kg (every 4 weeks)

Physician Signature* ______________________________

Date*(Order is Valid for One Year) ____________________
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Alzheimer's disease

_____ Other__________________________

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: ____________________

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Brain magnetic resonance imaging (MRI)

(WITHIN ONE YEAR)

____ Amyloid Beta Confirmation

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center   Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Oklahoma-------

___ Tulsa

6/2021