

PATIENT INFORMATION
 Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)
MEDICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

 Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

 MRI within 1 year attached

 Confirmed presence of amyloid pathology (CSF or PET scan) attached

Cognitive Assessment Date: _____ Name of Assessment: _____ Score: _____

Lab Orders: _____

ADUHELM ORDERS

 Administer Aduhelm IV every **4 weeks** as follows (SELECT ONE):

 Initial start w/ maintenance dosing:

- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

 Maintenance dosing only:

- 10mg/kg

** Once we receive all necessary documentation, we will schedule the patient's treatment

ADDITIONAL ORDERS/COMMENTS
PHYSICIAN INFORMATION

 By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS
 Alpharetta, GA Arlington, TX Atlanta, GA Austin, TX Bee Cave, TX Birmingham, AL Cape Coral, FL Clear Lake, TX Clearwater, FL Coppell, TX Creve Coeur, MO Dallas, TX
 Decatur, GA Denver, CO El Paso East, TX El Paso West, TX Fort Myers, FL Fort Worth, TX Hendersonville, TN Houston, TX Huntsville, AL Independence, MI Kansas City, MI
 Knoxville, TN Kyle, TX Lubbock, TX Montgomery, AL Murfreesboro, TN Naples, FL Nashville, TN North Hills, TX Plano, TX Round Rock, TX San Antonio, TX Sarasota, FL
 Smyrna, GA St. Louis, MI Stone Oak, TX Waco, TX West Houston, TX The Woodlands, TX Other: _____

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