Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Aduhelm™ (aducanumab-avwa)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Phone _____ Fax _____ NPI # _____ License # _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Clinic/Institution name _____ Office/Infusion clinic affiliation _____

If Infusion Site is different than Office/Clinic/Insitution - Please name _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site Contact name _____ Infusion site phone number _____

Infusion site e-mail _____ Infusion site facsimile number _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code: _____ ❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____ Patient wt _____ ❑ Lbs. ❑ Kg

Date wt obtained _____ Date of pre-treatment MRI _____ Date of most recent MRI _____

Next MRI scheduled _____ Has any prior MRI shown evidence of ❑ ARIA-H ❑ ARIA-E ❑ None

Please attach relevant chart notes, imaging (MRI/PET) findings, and plans of care for follow-up monitoring as these may be required to process payer authorizations.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

***Provide address for the selected shipment option.**
Check Unknown if assistance is needed to identify infusion site.

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Aduhelm™ (aducanumab-avwa)	170mg/1.7mL and/or 300mg/3mL vials	Infuse all doses as indicated below intravenously over 60 minutes every 4 weeks (at least 21 days apart) as per product labeling according to the following schedule **(enter dates to be dispensed)**: **Current weight** _____ ❑ kg ❑ lb **Date weight obtained** ____/____/____ **Titration** ❑ Dose 1, Infuse 1mg/kg, Date: _____ ❑ Already given ❑ Dose 2, Infuse 1mg/kg, Date: _____ ❑ Already given ❑ Dose 3, Infuse 3mg/kg, Date: _____ ❑ Already given ❑ Dose 4, Infuse 3mg/kg, Date: _____ ❑ Already given ❑ Dose 5, Infuse 6mg/kg, Date: _____ ❑ Already given ❑ Dose 6, Infuse 6mg/kg, Date: _____ ❑ Already given **Maintenance** ❑ Dose 7 and monthly thereafter, Infuse 10mg/kg, Maintenance Starting Date: _____ Unless otherwise indicated, all infusions to be diluted in 100mL bag of 0.9% Sodium Chloride and infused via peripheral intravenous access using a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.	Dispense: ❑ 1-month supply ❑ Other _____ Refills _____
		❑ Other instructions: _____	
		Supplies: (Supplies will not be sent with shipment unless indicated below. Pumps, access, and administration supplies to be supplied by infusion provider) ❑ Other supplies: _____	Send quantity sufficient for medication days supply

SITE OF CARE

EXPECTED DATE OF FIRST/NEXT INJECTION _____

Deliver product to: ❑ Office ❑ Infusion Site

Site of Care Delivery address _____

❑ Site of care unknown, or to be determined

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
By signing below, I certify that the above therapy is medically necessary.

PHYSICIAN SIGNATURE REQUIRED

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)**

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

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.

accredo®