

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Alzheimer's Disease with Early Onset	ICD 10 Code: G30.0	
<input type="checkbox"/> Alzheimer's Disease with Late Onset	ICD 10 Code: G30.1	
<input type="checkbox"/> Other Alzheimer's Disease	ICD 10 Code: G30.8	
+ EITHER <input type="checkbox"/> Dementia without Behavioral Disturbances	ICD 10 Code: F02.80	
Or <input type="checkbox"/> Dementia with Behavioral Disturbances	ICD 10 Code: F02.81	
<input type="checkbox"/> Mild Cognitive Impairment, So Stated	ICD 10 Code: G31.84	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Amyloid Beta Confirmation *Pt may be required to submit a pregnancy test prior to treatment
New Therapy Induction <input type="checkbox"/> Therapy Change <input type="checkbox"/> Therapy Continuation- Treatment start date: _____ Last Brian MRI: _____ Name of Cognitive Assessment Used: _____ Assessment Date: _____ Score: _____ Does Pt have a history of life threatening reaction to Aduhelm? <input type="checkbox"/> Yes <input type="checkbox"/> No		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders		
<input type="checkbox"/> J0172 Aduhelm	<input type="checkbox"/> Infusion 1: 1mg/kg <input type="checkbox"/> Infusion 2: 1mg/kg 4 weeks after infusion 1 <input type="checkbox"/> Infusion 3: 3mg/kg 4 weeks after infusion 2 <input type="checkbox"/> Infusion 4: 3mg/kg 4 weeks after infusion 3	<input type="checkbox"/> Infusion 5: 6mg/kg 4 weeks after infusion 4 <input type="checkbox"/> Infusion 6: 6mg/kg 4 weeks after infusion 5 <input type="checkbox"/> Maint Dose: 10mg/kg every 4 weeks after infusion 6  <b>NOTE: MRI's must be obtained prior to Infusions 5,7,9 and 12</b>
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen 500mg PO PRN <input type="checkbox"/> Benadryl 25mg PO or IV <input type="checkbox"/> Other: _____		<input type="checkbox"/> CBC    Date: _____ <input type="checkbox"/> CMP    Date: _____ <input type="checkbox"/> Other: _____    Date: _____
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: _____ Time: _____

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515  
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – ADUHELM**