Aducanumab-avwa (Aduhelm)

IVX HEALTH

Provider Order Form for 1st through 6th Infusion (See Therapy Administration for details.)

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

CAREGIVER OR HEALTH CARE REPRESENTATIVE INFORMATION

NOTE: Caregiver or representative must accompany patient during first visit.

Caregiver or representative name: Relationship:

Phone number: **Caregiver Status:** ☐ DPOA ☐ DPOAHC (Please provide a copy if applicable.)

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REFERRING PROVIDER

☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management & post-infusion observation.

☑ The patient and/or appropriate surrogate decision maker or DPOAHC has been provided informed consent for aducanumab, including communication of the potential benefits and burdens of treatment.

☑ Provide supporting clinical documents including:
- Positive beta amyloid pathology testing. (Amyloid Beta PET Scan or Cerebral Spinal Fluid (CSF) biomarker testing.)
  Clinical documentation including a neurologic evaluation and a relevant cognitive assessment test supporting accurate diagnosis and eligibility. Examples include: Clinical Dementia Rating Scale (CDR), Montreal Cognitive Assessment (MoCA), Functional Assessment Staging Tool (FAST), or Mini Mental Status Exam (MMSE).

☑ I have reviewed the MRI* and communicated the results to the patient or surrogate and want to proceed with infusion.

☑ I have attached MRI results that support the treatment plan of Aducanumab (Please provide results & date MRI completed.)

____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

NOTE: A new order must be completed prior to the 7th and 12th infusion verifying brain MRI was completed and reviewed.

☑ Infuse Aducanumab-avwa (Aduhelm) as an intravenous infusion once every four weeks.

☑ Mix in 100ml 0.9% sodium chloride, intravenous infusion over one hour (use micron in line filter, 0.2 or 0.22)
- Dosage Instruction:
  1mg/kg for infusions 1 and 2
  3 mg/kg for infusions 3 and 4
  6 mg/kg for infusions 5 and 6
- Frequency: once every 4 weeks:
- Flush with 0.9% sodium chloride at completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion/injection

☐ Patient is NOT required to stay for observation time

PRE-MEDICATION ORDERS (PRE-MEDICATIONS ARE OPTIONAL AND NOT REQUIRED BY MANUFACTURER)

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: ____________________________
Dose: ______________ Route: ______________
Frequency: ____________________________

*Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment. Obtain MRIs prior to 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg). If ≥ 10 new incident microhemorrhages or > 2 focal areas of superficial siderosis (radiographic severe ARIA-H) are observed, treatment may be continued with caution only after clinical evaluation and follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H).

Ordering Provider: Initial here _________ and proceed to the next page.

ADULT REACTION MANAGEMENT PROTOCOL

☑ Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

☑ If reaction occurs:

- If indicated, stop infusion.
- Maintain/establish vascular access.
- IVX Health clinicians have the following PRN medications available for the following reactions.
  - Headache, pain, fever >100.4F, chills or rigors- Acetaminophen 650mg PO or Ibuprofen 400mg PO.
  - Rhinitis, allergies, hives, pruritis and other nonspecific symptoms of allergic reaction - Loratadine 10mg PO or Diphenhydramine 25-50mg PO or IV
  - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
  - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
  - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 500ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
  - Hypertension (>30 mmHg increase from baseline or >180 mmHg SBP): Clonidine 0.1mg and wait 45 minutes, may administer Amlodipine 5mg if hypertension persists
  - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
  - Famotidine 20mg IV- Refractory to other treatments given
  - Solumedrol 125mg IV- Refractory to other treatments given.
- When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.
- Notify referring provider as clinically appropriate and follow clinical escalation protocol.

☑ **Severe allergic/anaphylactic reaction:**

- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension).
  - Call 911.
  - Initiate basic life support as needed.
  - Bring the **AED** to the patient (Attach pads if indicated).
  - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
  - Place patient in recumbent position, elevate lower extremities.
  - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
  - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
  - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
  - Administer **methylprednisolone** 125mg IVP, if not previously given.
  - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
  - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

______________________________ ______________________________

Patient Name **Patient Date of Birth**

____

Provider Name (Print)

______________________________ ______________________________

Provider Signature **Date**

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Aducanumab-avwa (Aduhelm)

IVX HEALTH

Provider Order Form for 7th through 11th Infusion (See Therapy Administration for details.)

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

CAREGIVER OR HEALTH CARE REPRESENTATIVE INFORMATION

NOTE: Caregiver or representative must accompany patient during first visit.

Caregiver or representative name: Relationship:

Phone number: **Caregiver Status:** ☐ DPOA ☐ DPOAHC (Please provide a copy if applicable.)

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REFERRING PROVIDER

- ☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management & post-infusion observation.
- ☑ The patient and/or appropriate surrogate decision maker or DPOAHC has been provided informed consent for aducanumab, including communication of the potential benefits and burdens of treatment.
- ☑ I have confirmed that prior to proceeding with infusions 7-11 that a repeat MRI* has been completed, reviewed, and results communicated to the patient or surrogate and want to proceed with infusion.
- ☑ I have attached MRI results that support the treatment plan of Aducanumab (Please provide results & date MRI completed.)

  ____

PRE-MEDICATION ORDERS (PRE-MEDICATIONS ARE OPTIONAL AND NOT REQUIRED BY MANUFACTURER)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: ____

  Dose: ____________________ Route: ________________

  Frequency: _____________________________________

THERAPY ADMINISTRATION

NOTE: This order is for infusions 7-11 only. A new order for infusions 12 and beyond will need to be completed along with brain MRI prior to 12th infusion.

- ☑ Infuse Aducanumab-avwa (Aduhelm) as an intravenous infusion once every four weeks.
- ☑ Mix in 100ml 0.9% sodium chloride, intravenous infusion over one hour (use micron in line filter, 0.2 or 0.22)
  - Dosage Instruction: 10 mg/kg for infusions 7-11
  - Frequency: once every 4 weeks:
  - Flush with 0.9% sodium chloride at completion of infusion
- ☐ Patient is required to stay for 30-minute observation post infusion/injection
- ☐ Patient is NOT required to stay for observation time

SPECIAL INSTRUCTIONS

*Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment. Obtain MRIs prior to 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg). If ≥ 10 new incident microhemorrhages or > 2 focal areas of superficial siderosis (radiographic severe ARIA-H) are observed, treatment may be continued with caution only after clinical evaluation and follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H).

Ordering Provider: Initial here _________ and proceed to the next page.

ADULT REACTION MANAGEMENT PROTOCOL

☑ Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

☑ If reaction occurs:

- If indicated, stop infusion.
- Maintain/establish vascular access.
- IVX Health clinicians have the following PRN medications available for the following reactions.
    - Headache, pain, fever >100.4F, chills or rigors- Acetaminophen 650mg PO or Ibuprofen 400mg PO.
    - Rhinitis, allergies, hives, pruritis and other nonspecific symptoms of allergic reaction - Loratadine 10mg PO or Diphenhydramine 25-50mg PO or IV
    - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
    - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
    - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 500ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
    - Hypertension (>30 mmHg increase from baseline or >180 mmHg SBP): Clonidine 0.1mg and wait 45 minutes, may administer Amlodipine 5mg if hypertension persists
    - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
    - Famotidine 20mg IV- Refractory to other treatments given
    - Solumedrol 125mg IV- Refractory to other treatments given.
- When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.
- Notify referring provider as clinically appropriate and follow clinical escalation protocol.

☑ **Severe allergic/anaphylactic reaction:**

- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension).
    - Call 911.
    - Initiate basic life support as needed.
    - Bring the **AED** to the patient (Attach pads if indicated).
    - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
    - Place patient in recumbent position, elevate lower extremities.
    - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
    - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
    - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
    - Administer **methylprednisolone** 125mg IVP, if not previously given.
    - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
    - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

Patient Name ____________________ **Patient Date of Birth** ____________________

Provider Name (Print) ____________________

Provider Signature ____________________ **Date** ____________________

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COLUMBUS: 844-627-2675 ____Dublin ____Pickerington ____Grove City

CINCINNATI: 844-946-0868 ____Colerain ____Hyde Park ____Union Centre

NASHVILLE: 844-627-2518 ____Brentwood ____Hendersonville

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Aducanumab-avwa (Aduhelm)

IVX HEALTH

Provider Order Form for 12th through XXX Infusion (See Therapy Administration for details.)

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

CAREGIVER OR HEALTH CARE REPRESENTATIVE INFORMATION

NOTE: Caregiver or representative must accompany patient during first visit.

Caregiver or representative name: Relationship:

Phone number: **Caregiver Status:** ☐ DPOA ☐ DPOAHC (Please provide a copy if applicable.)

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REFERRING PROVIDER

- ☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management & post-infusion observation.
- ☑ The patient and/or appropriate surrogate decision maker or DPOAHC has been provided informed consent for aducanumab, including communication of the potential benefits and burdens of treatment.
- ☑ I have confirmed that prior to proceeding with infusions 12 and beyond that a repeat MRI* has been completed, reviewed, and results communicated to the patient or surrogate and want to proceed with infusion.
- ☑ I have attached MRI results that support the treatment plan of Aducanumab (Please provide results & date MRI completed.)

  ____

PRE-MEDICATION ORDERS (PRE-MEDICATIONS ARE OPTIONAL AND NOT REQUIRED BY MANUFACTURER)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: ______________________________________

  Dose: ________________ Route: ______________

  Frequency: ___________________________________

THERAPY ADMINISTRATION

NOTE: This order is for infusions 12 and beyond.

- ☑ Infuse Aducanumab-avwa (Aduhelm) as an intravenous infusion once every four weeks.
- ☑ Mix in 100ml 0.9% sodium chloride, intravenous infusion over one hour (use micron in line filter, 0.2 or 0.22)
  - Dosage Instruction: 10mg/kg for infusions 12 and beyond
  - Frequency: once every 4 weeks:
  - Flush with 0.9% sodium chloride at completion of infusion

- ☐ Patient is required to stay for 30-minute observation post infusion/injection
- ☐ Patient is NOT required to stay for observation time

Refills: ☐ Zero / ☐ for 12 months / ☐ __________________ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment. Obtain MRIs prior to 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg). If ≥ 10 new incident microhemorrhages or > 2 focal areas of superficial siderosis (radiographic severe ARIA-H) are observed, treatment may be continued with caution only after clinical evaluation and follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H).

Ordering Provider: Initial here _________ and proceed to the next page.

ADULT REACTION MANAGEMENT PROTOCOL

☑ Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

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  - Rhinitis, allergies, hives, pruritis and other nonspecific symptoms of allergic reaction - Loratadine 10mg PO or Diphenhydramine 25-50mg PO or IV
  - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
  - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
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  - Hypertension (>30 mmHg increase from baseline or >180 mmHg SBP): Clonidine 0.1mg and wait 45 minutes, may administer Amlodipine 5mg if hypertension persists
  - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
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- When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.
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  - Call 911.
  - Initiate basic life support as needed.
  - Bring the **AED** to the patient (Attach pads if indicated).
  - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
  - Place patient in recumbent position, elevate lower extremities.
  - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
  - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
  - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
  - Administer **methylprednisolone** 125mg IVP, if not previously given.
  - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
  - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

Patient Name ______________________ **Patient Date of Birth** ______________________

Provider Name (Print) ______________________

Provider Signature ______________________ **Date** ______________________

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