PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Aduhelm (Aducanumab) Referral Form

Send your RX to:

Date Medication Needed: _____/_____/_____ Injection training by pharmacy? ☐

Ship to: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical)

Patient Name: _____ Birth Date: _____/_____/_____ Gender: ☐ Male ☐ Female

Height: _____ Weight: _____ ☐ lbs. ☐ kg. SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Phone: _____ Insurance Info: _____

Policy Number: _____ Known Allergies: _____

_____

2. PRESCRIBER INFORMATION

Provider Name: _____ DEA#: _____ NPI#: _____ TAX ID#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Key Contact: _____ Phone #: _____

3. DIAGNOSIS / CLINICAL INFORMATION

☐ G30.0 Alzheimer's Disease with Early Onset OR

☐ G30.1 Alzheimer's Disease with Late Onset OR

☐ G30.8 Other Alzheimer's Disease + F02.80 Dementia without Behavioral Disturbance **OR**

☐ F02.81 Dementia with Behavioral Disturbance

☐ G31.84 Mild Cognitive Impairment so stated

☐ Other: _____

Baseline Brain MRI within last year: ☐ YES ☐ NO Date of last Brain MRI: _____/_____/_____

Brain MRI before 7th dose: ☐ YES ☐ NO Date of MRI before 7th dose: _____/_____/_____

Brain MRI before 12th dose: ☐ YES ☐ NO Date of MRI before 12th dose: _____/_____/_____

Cognitive Assessment done: ☐ YES ☐ NO Date of Cognitive Assessment: _____/_____/_____

Name of Assessment: _____ Date:_____/_____/_____

Dosing Regimen:

- ☐ Infusion 1 and 2: 1mg/kg every 4 weeks
- ☐ Infusion 3 and 4: 3mg/kg 4 weeks after Infusion 2
- ☐ Infusion 5 and 6: 6mg/kg 4 weeks after Infusion 4
- ◉ Infusion 7 and beyond "Maintenance Dose" 10mg/kg every 4 weeks after Infusion 6

Premedication order as applicable:	Dosing:
☐ Solu-Cortef	
☐ Solu-medrol	
☐ Tylenol	
☐ Benadryl	
☐ Other: _____	

4. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____

Patient Signature Date

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner.
Prescribers are reminded patients may choose any pharmacy of their choice.