Aduhelm® (aducanumab-avwa) MRI Confirmation Documentation

Fax completed form, and clinical documentation (copy of MRI report) to: (800) 689-3147

option care health™	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Details needed for therapy:

- **Brain MRI must be provided prior to the 5th, 7th, 9th, and 12th infusions.**

MRI Confirmation Details

MRI completed on (date): _____

MRI completed prior to (check one):

☐ **5th infusion**

☐ **7th infusion**

☐ **9th infusion**

☐ **12th infusion**

MRI reviewed on (date): _____

Plan:

☐ **May continue dosing as ordered.**

☐ **Suspend dosing.**

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

