

Aduhelm® (aducanumab-avwa) MRI Confirmation Documentation

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

	Patient Name:		Date of Birth:	
	Address:			
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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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:

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