

# KISUNLA™ Referral Form



Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:			Date of Birth:
Referral Date:	New Referral	Updated Order	Order Renewal
Address:			City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Allergies:			
Current Medications:			
Other Medical Conditions or Additional Comments:			
Medical History Related to IV Insertion (e.g. lymph nodes or mastectomy):			

DIAGNOSIS			
Patient Diagnosis & ICD-10:	G30.0 - Alzheimer's disease with early onset G30.9 - Alzheimer's disease, unspecified	G30.1 - Alzheimer's disease with late onset G31.84 - Mild cognitive impairment	G30.8 - Other Alzheimer's disease
<b>Prescriber must indicate the following requirements have been met to confirm diagnosis &amp; that Patient has evidence of AD neuropathology &amp; has been assessed for baseline ARIA risk via MRI:</b>			
Amyloid pathology confirmed via: Amyloid PET Scan <b>-OR-</b> CSF Analysis <b>-OR-</b> Blood plasma Result: Amyloid positive Amyloid negative ( <i>Kisunla™ is not a treatment option for this Patient, if checked</i> )			Date:
Recent MRI obtained prior to initiating Kisunla™ (including FLAIR and T2/GRE or SWI) to assess ARIA risk Prescriber has verified that this Patient does not have evidence of prior ARIA-H			Date:
Completion of cognitive assessment type: MMSE MoCA CDR Other: Score: _____			Date:
Completion of functional assessment type: FAQ FAST Other: _____			Date:
Results for ApoE Testing			Date:
Completion of CMS approved CED registry ( <i>only required for Patients with Medicare</i> ) ClinicalTrials.gov Registry Number: NCT _____ Submission Number ( <i>if applicable</i> ): _____			CED Submission Date:
<b>Note: MRIs must be obtained prior to initial infusion to assess ARIA risk. During treatment, conduct an ARIA monitoring MRI before Infusions 2, 3, 4 and 7 and if symptoms consistent with ARIA occur.</b>			

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH	
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable	Vaccine status (any vaccination) and documentation of any recent vaccinations Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS	
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
<b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL <b>---OR---</b> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
<b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>	

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV as needed	Solu-cortef 250mg-500mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV as needed Other
<b>Pre-Medications:</b> (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO <b>---OR---</b> IV _____ minutes prior to infusion	Solu-Medrol _____ mg IV _____ minutes prior to infusion	Other
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? Yes No	If No, when was last dose given? _____ When is patient due for next dose? _____	
KISUNLA	<b>Induction:</b> 700mg IV infusion via gravity <b>---OR---</b> pump over 30 minutes every 4 weeks x 3 doses	NONE
	<b>Maintenance:</b> 1400mg IV infusion via gravity <b>---OR---</b> pump over 30 minutes every 4 weeks	_____
	If missed dose, administer the same dose as soon as possible and continue every 4 weeks. Obtain MRI prior to 2nd, 3rd, 4th, and 7th infusions. MRI results must be performed and cleared by MD to proceed to next infusion.	
OTHER		NONE

**By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.**

Prescriber's Signature \_\_\_\_\_  
 Dispense as Written  
 Print Name \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted  
 Print Name \_\_\_\_\_ Date \_\_\_\_\_

