KISUNLA™ Referral Form

Fax Completed Form To: **Phone:**

Amerita
YOUR INFUSION ADVOCATE

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 ☐ G30.1 - Alzheimer's disease with late onset ☐ G30.8 - Other Alzheimer's disease ☐ G30.9 - Alzheimer's disease, unspecified ☐ G31.84 - Mild cognitive impairment

Prescriber must indicate the following requirements have been met to confirm diagnosis & that Patient has evidence of AD neuropathology & has been assessed for baseline ARIA risk via MRI:

☐ Amyloid pathology confirmed via: ☐ Amyloid PET Scan ***-OR-*** ☐ CSF Analysis ***-OR-*** ☐ Blood plasma Result: ☐ Amyloid positive ☐ Amyloid negative *(Kisunla™ is not a treatment option for this Patient, if checked)*	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 *(only required for Patients with Medicare)* ClinicalTrials.gov Registry Number: NCT _____ Submission Number *(if applicable)*: _____	CED Submission Date:

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.

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

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

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV _____minutes prior to infusion ☐ Other

Supply Orders: 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	☐ **Induction**: 700mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes every 4 weeks x 3 doses	NONE
	☐ **Maintenance**: 1400mg IV infusion via ☐ gravity ***---OR---*** ☐ 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 assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

ameritaiv.com

THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

URAC ACCREDITED Specialty Pharmacy 08/01/2022 · ACHC ACCREDITED · PCAB ACCREDITED Compounding Pharmacy