# Kisunla

INFUSION FOR HEALTH

Treatment Location: _____

**PROVIDERS: Please include the following to expedite the order:**
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Medication List, Confirmation of the Presence of Amyloid Beta Pathology (PET, LP), Recent Brain MRI Establishing Presence/Lack of Pre-existing ARIA, and the Results of ApoE e4 Genetic Testing if Done

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G30.0 ☐ G30.1 ☐ G30.8 ☐ G30.9 ☐ G31.84 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

## PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

## NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ Results of follow-up MRIs will be required PRIOR to administering the 2nd, 3rd, 4th, and 7th infusion.
- ☐ Check this box if you DO NOT authorize Infusion for Health to interpret MRI results
- ☑ Clinical Trial Number (8 digits): NCT _____

## LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ Frequency: _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## PRE-MEDICATION ORDERS

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

## THERAPY ADMINISTRATION

- ☑ Kisunla Intravenous Infusion

**Dose:**

- ☐ Infusions 1, 2, and 3: 700 mg/100 ml NS IV every 4 weeks
- ☐ Infusion 4 and Beyond: 1400 mg / 250 ml NS IV every 4 weeks

- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated order will expire one year from date signed)

*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

## SPECIAL INSTRUCTIONS:

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***