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, the Results of ApoE e4 Genetic Testing if Done, CMS Registry Number, Clinical Trial Number

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

☑ CMS Registry Number: ALZH ____________

Clinical Trial Number (8 digits): NCT ____________

All Medicare patients must be enrolled in a qualifying study and will not be scheduled without this information.

PRE-MEDICATION ORDERS

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV

☐ Other: ____________

Dose: ________ Route: ________ Frequency: ________

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.

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.***