

Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order:** Patient Demographics, Most Recent Office Visit Note, Insurance Information, Confirmation of the Presence of Amyloid Beta Pathology (PET, LP), Recent Brain MRI Establishing Presence/Lack of Pre-existing ARIA, 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.