Kisunla

INFUSION FOR HEALTH

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing (Cognitive Screening, Amyloid Beta Pathology on Pet/LP, Recent Brain MRI); Most Recent Office Visit Note, CMS Registry Number, Clinical Trial Number

PATIENT INFORMATION

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

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

Pre-medications not usually indicated.

☐ 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:

☐ Initial Doses (please indicate if patient has received any initial doses):
Infusion 1: 350 mg
Infusion 2: 700 mg
Infusion 3: 1050 mg

☐ Week 4 and Beyond: 1400 mg

☑ Frequency: 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.

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.*