

☐ **STAT REFERRAL**

KISUNLA ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

Does patient have venous access? ☐ YES ☐ NO If yes, what type ☐ MEDIPORT ☐ PIV ☐ PICC LINE ☐ OTHER: _____

- a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

- _____ Perform port flush every _____ weeks per hospital policy.
_____ Perform IV site care per hospital protocol.
_____ Activase 2mg IVP per hospital protocol.

DUAL DIAGNOSIS IS REQUIRED – SELECT ONE OPTION OF BOTH CONDITIONS THAT APPLY FROM BELOW:

- ☐ G30.0 Alzheimer's Disease, Early Onset ☐ F02.80 Dementia without behavioral disturbance
☐ G30.1 Alzheimer's Disease, Late Onset ☐ F02.81 Dementia with behavioral disturbance
☐ G30.8 Other Alzheimer's disease **← G30.X codes require secondary F02.8X code →**
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild Cognitive Impairment, So Stated
☐ Other: _____ (ICD 10 + Description)

Prescriber must indicate the following requirements have been met (please provide documentation):

- ☐ Beta Amyloid Pathology Confirmed Via
☐ Amyloid PET Scan Date: _____ OR ☐ CSF Analysis Date: _____ Result: _____
☐ Cognitive Assessment Used: _____ Date: _____ Result: _____
☐ ApoE ε4 Genetic Test Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier
☐ CMS Alzheimer National Patient Registry Number: ALZH - _____ ☐ National Clinical Trial Number: NCT - _____

PRESCRIPTION ORDERS

SELECT	DRUG	TITRATED DOSING	ROUTE	TITRATED SCHEDULE	DURATION
☐	Kisunla	350 mg	IV Over At Least 30 Minutes	Infusion 1	1 time
☐	Kisunla	700 mg	IV Over At Least 30 Minutes	Infusion 2 (4 weeks after infusion 1)	1 time
☐	Kisunla	1050 mg	IV Over At Least 30 Minutes	Infusion 3 (4 weeks after infusion 2)	1 time
☐	Kisunla	1400 mg	IV Over At Least 30 Minutes	Infusion 4 and Beyond (4 weeks after infusion 3 and then every 4 weeks thereafter)	12 Months

Pre-Infusion:

- ☒ Confirm baseline MRI results prior to initiation of treatment.
☒ Confirm MRI completed and reviewed by prescriber prior to the 2nd, 3rd, 4th and 7th treatment.
☒ Measure and record weight prior to each treatment to determine dose.
☒ Hold infusion and notify provider if patient reports:
- Headache.
 - Dizziness.
 - Nausea.
 - Vision changes.
 - New or worsening confusion.

Post-Infusion:

- ☒ Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.