

KISUNLA™ Referral Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION			
Patient Name:			Date of Birth:
Referral Date:	☐ New Referral ☐ Updated Order ☐ Order Renewal		
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	☐ Male ☐ Female
Allergies:			
Current Medications:			
Other Medical Conditions or Additional Comments:			
Medical History Related to IV Insertion (e.g. lymph nodes or mastectomy):			
DIAGNOSIS			
Patient Diagnosis & ICD-10: ☐ G30.0 - Alzheimer's disease with early onset ☐ G30.1 - Alzheimer's disease with late onset ☐ G30.8 - Other Alzheimer's disease ☐ G30.9 - Alzheimer's disease, unspecified ☐ G31.84 - Mild cognitive impairment			
Prescriber must indicate the following requirements have been met to confirm diagnosis & that Patient has evidence of AD neuropathology & has been assessed for baseline ARIA risk via MRI:			
☐ Amyloid pathology confirmed via: ☐ Amyloid PET Scan -OR- ☐ CSF Analysis -OR- ☐ Blood plasma Result: ☐ Amyloid positive ☐ Amyloid negative (<i>Kisunla™ is not a treatment option for this Patient, if checked</i>)			Date:
☐ Recent MRI obtained prior to initiating Kisunla™ (including FLAIR and T2/GRE or SWI) to assess ARIA risk ☐ Prescriber has verified that this Patient does not have evidence of prior ARIA-H			Date:
☐ Completion of cognitive assessment type: ☐ MMSE ☐ MoCA ☐ CDR ☐ Other: Score: _____			Date:
☐ Completion of functional assessment type: ☐ FAQ ☐ FAST ☐ Other:			Date:
☐ Results for ApoE Testing			Date:
☐ Completion of CMS approved CED registry (<i>only required for Patients with Medicare</i>) ClinicalTrials.gov Registry Number: NCT _____ Submission Number (if applicable): _____			CED Submission Date:
<i>Note: MRIs must be obtained prior to initial infusion to assess ARIA risk. During treatment, conduct an ARIA monitoring MRI before Infusions 2, 3, 4 and 7 and if symptoms consistent with ARIA occur.</i>			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	DEA #:
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:		Phone:	Fax:
Supervisory Physician (if applicable):			
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates) ☐ Line access documentation/verification if applicable		☐ Vaccine status (any vaccination) and documentation of any recent vaccinations ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
Fluid Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
Lab Orders: _____ Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed (Check all that apply) ☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other			
Pre-Medications: ☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV _____ minutes prior to infusion (Check all that apply) ☐ Diphenhydramine _____ mg ☐ PO ---OR--- ☐ IV _____ minutes prior to infusion ☐ Other			
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
☐ KISUNLA	☐ Induction ramp up: Week 0: 350mg IV infusion, Week 4: 700mg IV infusion, Week 8: 1050mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes		NONE
	☐ Maintenance: Week 12 and every 4 weeks thereafter: 1400mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes If missed dose, administer the same dose as soon as possible and continue every 4 weeks. Obtain MRI prior to 2nd, 3rd, 4th, and 7th infusions. MRI results must be performed and cleared by MD to proceed to next infusion.		
☐ OTHER			NONE

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature _____
Dispense as Written Print Name _____ Date _____

Prescriber's Signature _____
Substitution Permitted Print Name _____ Date _____