



Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: 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, so stated

Patients weight: _____
Lab Date: _____
Allergies: _____

MUST CHECK BOX: Z00.6.
Patient is in registry to receive treatment.

ALSO INCLUDE...
Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

ALZH _____ Date ALZH Secured _____

KISUNLA ORDER

Infusions 1-3
Kisunla Dosing
Infusion 1: 350mg
Infusion 2: 700mg
Infusion 3: 1050mg
Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.

Infusion 4
Kisunla Dosing: 1400mg
Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.

Infusion 5-6
Kisunla Dosing: 1400mg
Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.

Infusions 7+
Kisunla Dosing: 1400mg
Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.

MRI required prior to EACH infusion.

DATE OF MRI: _____

Beta Amyloid Pathology has been confirmed via CSF or PET.

MRI required prior to infusion.
DATE OF MRI: _____

MRI not required prior to infusion 5 and 6.

MRI required prior to infusion 7.

DATE OF MRI: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Phone: _____

Practice Address: _____

Office Contact: _____

Fax: _____

NPI/ TIN: _____

Referring Physician's Signature _____

Date: _____



Patient Name: _____

Please Attach All Insurance Information, front and back

POST-INFUSION MONITORING

Monitor the patient in the infusion center for 30 minutes after each infusion.

KISUNLA PRE MEDICATION ORDER (OPTIONAL)

PreMeds:

Diphenhydramine IV - Inject 25 - 50 mg IV PRN. Do not give with oral diphenhydramine.
Confirm patient is not driving home.

Diphenhydramine 25mg PO - Give 1-2 tablets PO PRN. Do not give with IV diphenhydramine.
Confirm patient is not driving home.

Acetaminophen 325/500mg PO - Give 1-2 tablets PO PRN to prevent headache/pain.

Ondandestron 4mg IV - Inject 4mg PRN to prevent nausea. May repeat in 30 minutes to a max dose of 8mg IV total.

For the first 3 infusions, give acetaminophen 650mg PO and cetirizine 10mg PO prior to the infusion. Then follow standard hypersensitivity protocol. After the 3rd infusion, give acetaminophen 650mg PO and cetirizine 10mg PO as needed.

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____