



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: \_\_\_\_\_

**ALSO INCLUDE...**

- Clinical/ Progress Notes
- Insurance Cards
- Demographics Sheet
- Current Medications
- Labs

**MUST CHECK BOX: Z00.6.**

**Patient is in registry to receive treatment.**

ALZH \_\_\_\_\_ Date ALZH Secured \_\_\_\_\_

### KISUNLA ORDER

Infusions 1-3	Infusion 4	Infusion 5-6	Infusions 7+
<b>Kisunla Dosing</b> 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.  <b>MRI required prior to EACH infusion.</b>  <b>DATE OF MRI:</b> _____  Beta Amyloid Pathology has been confirmed via CSF or PET.	Kisunla Dosing: 1400mg  Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.  <b>MRI required prior to infusion.</b>  <b>DATE OF MRI:</b> _____	Kisunla Dosing: 1400mg  Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.  <b>MRI not required prior to infusion 5 and 6.</b>	Kisunla Dosing: 1400mg  Infused every 4 weeks over 30 minutes. Patient must be observed for 30 minutes post infusion.  <b>MRI required prior to infusion 7.</b>  <b>DATE OF MRI:</b> _____

### PHYSICIAN INFORMATION

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI/ TIN: \_\_\_\_\_

Referring Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_



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### 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.

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**NPI/ TIN:** \_\_\_\_\_

**Referring Physician's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_