EPSRx A CarePartners Pharmacy Company | CarePartners Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

KISUNLA™ RX ENROLLMENT FORM

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐M ☐F Weight: _____(lbs) Height: _____

Allergies: _____

Is patient the main point of contact? ☐ Yes ☐ No

If not, who? Name/Relationship: _____

Phone Number: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION - AND - Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance: (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

MEDICARE/MEDICARE ADVANTAGE PATIENTS ONLY:

CMS Registry # (ALZH#): _____

CMS Registry Enrollment Date: _____

CLINICAL INFORMATION

Please Select Diagnosis:

☐ G30.0 Alzheimer's disease with early onset ☐ G30.1 Alzheimer's disease with late onset ☐ G30.8 Other Alzheier's disease

☐ G30.9 Alzheimer's disease, unspecified ☐ G31.84 Mild cognitive impairment, so stated ☐ Other: _____

Prescriber must indicate the following requirements have been met to confirm diagnosis and that Patient has evidence of AD neuropathology and has been assessed for baseline ARIA risk via MRI:

☐ **Amyloid pathology confirmed via:**
☐ Amyloid PET scan ☐ CSF Analysis ☐ Blood Plasma Date: _____ Result: ☐ Amyloid Positive ☐ Amyloid Negative

☐ **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: _____ Date: _____

☐ **Completion of functional assessment type:**
☐ FAQ ☐ FAST ☐ Other: _____ Date: _____

**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 if symptoms consistent with ARIA occur.

DRUG ORDERS

Prescription type: ☐ New Start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

☐ Please provide nursing and supplies for home infusion.

Dose/Frequency	Quantity	Refills
Starting Doses: Infuse once every 4 weeks per the dosing schedule below ☐ Infusion 1: Infuse 350mg intravenously over approximately 30 minutes ☐ Infusion 2: Infuse 700mg intravenously over approximately 30 minutes ☐ Infusion 3: Infuse 1050mg intravenously over approximately 30 minutes **Continued Dose:** ☐ Infusion 4+: Infuse 1400mg intravenously over approximately 30 minutes once every 4 weeks thereafter	☐ 1 Vial ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials	☐ _____

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Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine (if not driving)	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ OR Cetirizine (if driving)	☐ 10mg PO	☐ Take 1 tablet PO prior to infusion
☐ _____	_____	_____

INFUSION REACTION ORDERS

Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus.

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions.

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:
☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:	PICC:	Implanted Port, Tunneled Catheter, and Nontunneled Catheter:
☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **NY & Iowa** providers, please submit electronic prescription.

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD-10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.