

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: _____ Secondary Insurance: (If Applicable): _____
 Plan #: _____ Plan #: _____
 Group #: _____ Group #: _____
 RX Card (PBM): _____ RX Card (PBM): _____
 BIN: _____ PCN: _____ 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 Alzheimer'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

☐ _____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to EPSrx or any of its subsidiaries using the contact information provided on this coversheet. This referral form is intended to assist with the processing of the patient's prescription and can be used at any pharmacy of the patient's choosing. It is not limited to the pharmacy listed on the form, nor does it imply that the patient is required to fill their prescription at a specific location. Patients maintain the right to select the pharmacy that best meets their needs. Please refer to TSBP Rule 281.7(15) for further guidance.

KISUNLA™ RX ENROLLMENT FORM

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 mid-antrolateral 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:

- ☒
- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

- ☒
- 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:

- ☒
- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

- ☒
- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Nontunneled Catheter:

- ☒
- 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.