

# KISUNLA REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049

PHONE: +1(844) 650-5802



## 1 PATIENT'S INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  MALE  FEMALE  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_ SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## 2 INSURANCE (Please attach If Available a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group: \_\_\_\_\_  
 Primary RX Insurance: \_\_\_\_\_ ID No: \_\_\_\_\_ RX GRP: \_\_\_\_\_ RX BIN: \_\_\_\_\_ RX PCN: \_\_\_\_\_

## 3 DIAGNOSIS AND CLINICAL INFORMATION

Is the patient already on Kisunla Infusions?  Yes  No If YES, Last Treatment Date: \_\_\_\_\_

If NO, what therapies has the patient trialed and failed? \_\_\_\_\_

### Diagnosis (ICD-10) and Patient Clinical Information:

Diagnosis (ICD-10) Code: \_\_\_\_\_ Description: \_\_\_\_\_

### Imaging to confirm presence of amyloid beta pathology:

Baseline and most recent MRI results (within the past year) Original MRI Diagnosis Date: \_\_\_/\_\_\_/\_\_\_ Recent MRI Date: \_\_\_/\_\_\_/\_\_\_

or Baseline and most recent PET scan: Original PET Scan Diagnosis Date: \_\_\_/\_\_\_/\_\_\_ Recent PET Scan Date: \_\_\_/\_\_\_/\_\_\_

APOE ε4 Carrier Status:  Homozygous  Heterozygous  Non-carrier

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:

CMP  CBC w/diff  MRI  PET Scan  APOE ε4 Carrier Status

## 4 PRESCRIPTION INFORMATION

Access:  Intravenous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILL
<input type="checkbox"/> KISUNLA	350 mg/20 mL	Administer every 4 weeks as an IV infusion over approximately 30 minutes at the following dosing schedule: <input type="checkbox"/> <b>BASELINE MRI</b> ; Date: ___/___/___ Dose ONE: Administer 350 mg IV over approximately 30 minutes. <input type="checkbox"/> <b>MRI (prior to 2<sup>nd</sup> Dose)</b> ; Date: ___/___/___ Dose TWO: Administer 700 mg IV over approximately 30 minutes. <input type="checkbox"/> <b>MRI (prior to 3<sup>rd</sup> Dose)</b> ; Date: ___/___/___ Dose THREE: Administer 1,050 mg IV over approximately 30 minutes. <input type="checkbox"/> <b>MRI (prior to 4<sup>th</sup> Dose)</b> ; Date: ___/___/___ Dose FOUR: Administer 1,400 mg IV over approximately 30 minutes. Dose FIVE: Administer 1,400 mg IV over approximately 30 minutes. Dose SIX: Administer 1,400 mg IV over approximately 30 minutes. <input type="checkbox"/> <b>MRI (prior to 7<sup>th</sup> Dose)</b> ; Date: ___/___/___ Dose SEVEN +: Continue 1,400 mg IV every 4 weeks thereafter.	Quantity: Q.S	Refills: 1 YEAR

### PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> SoluMedrol® (IV)	Give _____ mg prior to infusion via <input type="checkbox"/> IV push <input type="checkbox"/> diluted in _____ mL of NS over 30 min.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Loratadine (PO)	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Acetaminophen (PO)	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN

### ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input checked="" type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial or (x2) Pen(s)	Refills: PRN
<input checked="" type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial	Refills: PRN
<input checked="" type="checkbox"/> SODIUM CHLORIDE 0.9% (IV)	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: Q.S	Refills: PRN

### NURSING/ LABS/ INFUSION SUPPLIES:

**NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

**INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.

**FLUSHING PROTOCOL:**  Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.

Heparin:  10 Units/mL  100 Units/mL, \_\_\_\_\_ as final flush and/or PRN to maintain patency

## 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: \_\_\_\_\_ Title:  MD  DO  ND  PA  APRN NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

DISPENSE AS WRITTEN  BRAND MEDICALLY NECESSARY  DO NOT SUBSTITUTE  May Substitute /  Product Selection Permitted /  Substitution Permissible  
 NO SUBSTITUTION /  DAW /  MAY NOT SUBSTITUTE

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.  
**CONFIDENTIALITY NOTICE:** The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to [info@ivsolutionsrx.com](mailto:info@ivsolutionsrx.com) and destroy all copies of the original message.

**THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE**

*#welcome to our family*