



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	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: _____

CLINICAL INFORMATION	
<b>Please Select Diagnosis:</b>	
<input type="checkbox"/> G30.0 Alzheimer's disease with early onset	<input type="checkbox"/> G30.1 Alzheimer's disease with late onset
<input type="checkbox"/> G30.9 Alzheimer's disease, unspecified	<input type="checkbox"/> G31.84 Mild cognitive impairment, so stated
	<input type="checkbox"/> G30.8 Other Alzheimer's disease
	<input type="checkbox"/> Other: _____
<b>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:</b>	
<input type="checkbox"/> <b>Amyloid pathology confirmed via:</b>	
<input type="checkbox"/> Amyloid PET Scan <input type="checkbox"/> CSF analysis <input type="checkbox"/> Blood plasma	Date: _____ Result: <input type="checkbox"/> Amyloid Positive <input type="checkbox"/> Amyloid Negative
<input type="checkbox"/> <b>Recent MRI obtained prior to initiating Kisunla™ (including FLAIR and T2/GRE or SWI) to assess ARIA risk</b>	
<input type="checkbox"/> Prescriber has verified that this Patient does not have evidence of prior ARIA-H	Date: _____
<input type="checkbox"/> <b>Completion of cognitive assessment type:</b>	
<input type="checkbox"/> MMSE <input type="checkbox"/> MoCA <input type="checkbox"/> CDR <input type="checkbox"/> Other: _____	Date: _____
<input type="checkbox"/> <b>Completion of functional assessment type:</b>	
<input type="checkbox"/> FAQ <input type="checkbox"/> FAST <input type="checkbox"/> Other: _____	Date: _____
<input type="checkbox"/> <b>Completion of CMS approved CED registry (only required for Patients with Medicare) ClinicalTrials.gov Registry Number: NCT _____</b>	
CED Submission Date: _____	Submission Number (if applicable): _____
<b>**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 and if symptoms consistent with ARIA occur.</b>	

ORDERS		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____		
Dose/Frequency	Quantity	Refills
<input type="checkbox"/> Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3	<input type="checkbox"/> 1 Vial <input type="checkbox"/> 2 Vials	<input type="checkbox"/> 2
<input type="checkbox"/> Alternate Starting Dose: Infuse 350mg infusion 1, 700mg infusion 2, and 1050mg infusion 3 once every 4 weeks	<input type="checkbox"/> 3 Vials <input type="checkbox"/> 4 Vials	<input type="checkbox"/> 0
<input type="checkbox"/> Maintenance Dose: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter		
Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> _____	_____	_____

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**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 or urticaria

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 Non-tunneled 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**

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber Signature

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.

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