TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

KISUNLA™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

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: _____

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: _____

☐ **Completion of CMS approved CED registry (only required for Patients with Medicare) ClinicalTrials.gov Registry Number: NCT _____**
CED Submission Date: _____ Submission Number (if applicable): _____

****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.**

ORDERS

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

Dose/Frequency	Quantity	Refills
☐ Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3	2 Vials	2
☐ Maintenance Dose: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 Vials	_____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion

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☐ _____	_____	_____

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.