



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	
Please Select Diagnosis:	
<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: _____
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:	
<input type="checkbox"/> Amyloid pathology confirmed via:	
<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"/> Recent MRI obtained prior to initiating Kisunla™ (including FLAIR and T2/GRE or SWI) to assess ARIA risk	
<input type="checkbox"/> Prescriber has verified that this Patient does not have evidence of prior ARIA-H	Date: _____
<input type="checkbox"/> Completion of cognitive assessment type:	
<input type="checkbox"/> MMSE <input type="checkbox"/> MoCA <input type="checkbox"/> CDR <input type="checkbox"/> Other: _____	Date: _____
<input type="checkbox"/> Completion of functional assessment type:	
<input type="checkbox"/> FAQ <input type="checkbox"/> FAST <input type="checkbox"/> Other: _____	Date: _____
<input type="checkbox"/> 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: <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
<input type="checkbox"/> Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3		2 Vials
<input type="checkbox"/> Maintenance Dose: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter		4 Vials
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"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion

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<input type="checkbox"/>	_____	_____	_____
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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