Jean Walter Kisunla Order Form

P: 443-354-3772 F: 443-354-3767

***Please complete this form in it's entirety to avoid delay in treatments.**

Patient Name

DOB: Phone number:

Full Address:

Allergies: Referring Provider:

NPI/DEA: Office contact and phone number:

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

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 **OR** ☐ CSF analysis **OR** ☐ Blood plasma Date: _____ Result: ☐ Amyloid Positive ☐ Amyloid Negati
- AND ☐ 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: _____
  - (Kisunla™ is not a treatment optic for this Patient, if checked)
- AND ☐ Completion of cognitive assessment type:
  - ☐ MMSE ☐ MoCA ☐ CDR ☐ Other _____ Date: _____
- AND ☐ Completion of functional assessment type:
  - ☐ FAQ ☐ FAST ☐ Other _____ Date: _____
- AND ☐ 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.

Kisunla™ Prescription — Fill out corresponding prescription below and sign at the bottom of the page

You must select at least one Dosing option. You may select both.

Kisunla™ Dosing	Quantity	Days Supply	Refills
☐ Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3	2 vials	28	2
☐ Maintenance Dose: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 vials	28	_____

Premedications: ◯ PLEASE CHECK HERE IF NO PREMEDICATION(S) REQUIRED

◯ Tylenol: _____ ◯ Benadryl: _____ ◯ Solumedrol: _____ ◯ Other: _____

PRESCRIBER CERTIFICATION: By signing I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed Kisunla to the previously identified patient or a physician's designee, and that I provided the patient with a description of Kisunla.

Provider Signatue: _____ Date: _____