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:

PATIENT HEIGHT AND WEIGHT: _____

DOCUMENTATION PROVIDED:	**Yes**	**No**
1. Baseline MRI done within 12 months? *Please attach report.	◯	◯
2. Has APoE testing been completed?	◯	◯
3. Has a CBC been done within the last 12 months? *Please attach results.	◯	◯
4. If patient has **MEDICARE**-Have they been registered through the CMS Registry? *Please attach submission with patient ID number.	◯	◯
5. Has the patient had a PET scan done? *Please attach report.	◯	◯

Order details:

Please select all that apply (This order is valid for 6 months):

◯ Loading dose (Every 4 weeks):
- Infusion 1: 350 mg IV
- Infusion 2: 700 mg IV
- Infusion 3: 1050 mg IV
- Infusion 4 and beyond: 1400 mg IV

◯ Maintenance Dose:
1400 mg IV every 4 weeks

Diagnosis code: **Refills:**

Premedications: ****If nothing is indicated below, we will use FDA recommendations****

◯ PLEASE CHECK HERE IF NO PREMEDICATION(S) REQUIRED

◯ Acetaminophen: _____mg ◯ Diphenhydramine: _____mg ◯ Solumedrol: _____mg

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: _____