Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Encounter for examination for normal comparison an control in clinical research program **(Medicare/Medicare Advantage only: select this code and a secondary code(s) below)**	ICD 10 Code: Z00.6
☐ Alzheimer's disease with early onset	ICD 10 Code: G30.0
☐ Alzheimer's disease with late onset	ICD 10 Code: G30.1
☐ Other Alzheimer's disease	ICD 10 Code: G30.8
☐ Alzheimer's disease, unspecified	ICD 10 Code: G30.9
☐ Mild Cognitive Impairment of uncertain or unknown etiology	ICD 10 Code: G31.84 (must use **in addition** to above codes)
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider	☐ Clinical/Progress notes (most recent)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Baseline MRI within 1 year	*Patient may be required to submit a pregnancy test prior to treatment

List Tried & Failed Therapies, including duration of treatment:

1)

Prescriber must indicate that the following requirements have been met (provide supporting documentation)

☐ Beta Amyloid Pathology Confirmed via:

↳ ☐ Amyloid PET Scan Date: _____ Result: _____

OR ☐ CSF Analysis Date: _____ Result: _____

OR ☐ Blood Plasma Date: _____ Result: _____

☐ Cognitive Assessment Used: _____ Date: _____ Result: _____

☐ ApoE ∈e4 Genetic Test - Date: _____ Result: _____ ☐ Omozygote ☐ Heterozygote ☐ Noncarrier

☐ Completion of CMS approved CED registry:: CED Submission Date: _____ Submission number: _____

☐ MRI of brain for ARIA monitoring prior to Infusions: ☐ 2, ☐ 3, ☐ 4, and ☐ 7, and if symptoms consistent with ARIA occur.

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

☐ Administer Kisunla as an intravenous infusion over approximately 30 minutes every four weeks as follows:

• Infusion 1: 350mg • Infusion 2: 700mg • Infusion 3: 1,050mg • Infusion 4 and beyond: 1,400mg

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr.
Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr.
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Effingham, IL 62401
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Effective Date: 9/17/24
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1257

INFUSION ORDERS - KISUNLA (DONANEMAB-AZBT)

Clinics Scan to: Physician Orders