Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

Kisunla

INFUSE ONE

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Tried/Failed Therapies
- MRI within 1 year
- CSF or PET Scan Showing Amyloid Pathology
- Cognitive Assessment & Score
- Most Recent Labs
- Medicare Registry #_____
- Functional Assessment & Score

PRIMARY AND SECONDARY DIAGNOSIS

Primary Diagnosis:
☑ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary 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: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Kisunla

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions

☐ Kisunla 700mg IV at week 0, 4, and 8, followed by 1400mg IV every 4 weeks thereafter

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infuse One's protocol (See flexcareinfusion.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infuse One's protocol (See infuseone.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____