MEDICA HEALTHCARE SERVICES
INJECTIONS AND INFUSION SPECIALTY
CHRONIC & RARE DISEASES

KISUNLA Medication Order Form

PATIENT DEMOGRAPHICS

Patient Name:_____ Patient's Phone Number: _____

Date of Birth: _____ Address: _____

☐ NKDA Allergies: _____ City, State, ZIP: _____

Weight: _____ lbs or_____kg Patient's email: _____

KISUNLA THERAPY ADMINISTRATION

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

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

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____

PRE MEDICATIONS (please write in): _____

****MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th and 7th infusion****

NURSING

Infusion to be administered per Medica Infusion's protocols.

REQUIRED DIAGNOSIS (Select One)

☐ Mild Cognitive Impairment Due to Alzheimer's Disease– G31.84
☐ Early Onset Alzheimer's Disease – G30.0
☐ Late Onset Alzheimer's Disease – G30.1
☐ Other Alzheimer's Disease – G30.8
☐ Alzheimer's Disease unspecified-G30.9

REQUIRED DOCUMENTATION:

**** Medicare patients must be registered with CMS prior to Treatment https://qualitynet.cms.gov/alzheimers-ced registry/submission**

☐ Patient Demographics
☐ Insurance Card/Information
☐ Progress Notes Supporting DX
☐ Current Medication List and H&P
☐ Cognitive Assessment Score _____ (MMSE 20-28, CDR-GS 0.5 or 1)
☐ MRI Within 1 Year
☐ Confirmed presence of amyloid pathology
☐ CMS Registry Confirmation ALZH-_____ (Medicare and Medicare Advantage only)
☐ ApoE ε4 Testing (if available)
☐ Patient has been provided ARIA Risk counseling

ORDERING PHYSICIAN

Signature: _____ Date: _____

Provider's name: _____ Fax: _____

Physician NPI: _____ Physician's DEA: _____

PLEASE SELECT PREFERRED PATIENT LOCATION:

- ☐ 105 Commerce St, # 109, Lake Mary, FL 32746
- ☐ 4850 W Oakland Park Blvd, #104, Lauderdale Lakes, FL 33313
- ☐ 3401 PGA Blvd, STE 540, Palm Beach Gardens, FL 33410
- ☐ 5210 Linton Blvd, STE 207, Delray Beach, FL 33484
- ☐ 3654 SW 30th Ave, Palm City, FL 34990

PLEASE FAX ORDER TO:

Fax: 561-207-7848

Phone: 689-488-1430

info@medicainfusion.com

www.medicainfusion.com