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
☐ Patient demographics AND insurance information
☐ Baseline MRI within 1 year
☐ Clinical/Progress notes (most recent)
☐ Labs and Tests supporting primary diagnosis
*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.

Initial Dosing	☐ J0175 Kisunla 700mg IV once every 4 weeks for infusions 1, 2, and 3
Maintenance Dosing	☐ J0175 Kisunla 1400mg IV once every 4 weeks thereafter

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.
Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - KISUNLA (DONANEMAB-AZBT)

Clinics Scan to: Physician Orders