



BAMF Health Theranostics Center • Molecular Therapy Clinic  
 109 Michigan Street NW, Suite #200, Grand Rapids, MI 49503  
 Phone: (888) 870-8998 • Fax: (616) 253-8365  
 bamfhealth.com

**Kisunla Order**  
 Revision 11-15-2024

**Please Fax completed order to BAMF Health at Fax # 616-253-8365**

**PATIENT INFORMATION**

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Height (cm): \_\_\_\_\_

ICD-10 Code(s) & Description: \_\_\_\_\_

**NOTE:** Please send all relevant demographic and insurance information

The patient has an existing prior authorization:  Yes (please fax copy to BAMF Health)  NO

**REFERRING OFFICE**

Contact Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**DIAGNOSIS**

- Mild cognitive impairment, so stated (ICD-10 code: G31.84)
- Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)
- Alzheimer's Disease with Early Onset (ICD-10 code: G30.0)
- Mild dementia due to Alzheimer's Disease (ICD-10 code: G30.9)
- Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

**CLINICAL HISTORY – REQUIRED INFORMATION**

- Current Medication list
- Recent provider note(s)
- PET scan or CSF results with amyloid beta confirmation
- Recent MRI of brain (within past year)
- Results of cognitive assessment with score: \_\_\_\_\_ (MMSE 22-30, CDR-GS 0.5 or 1)
- Confirmation of functional impairment w/ validated tool:
  - FAQ Score  FAST  CDR-SB
  - For Medicare / Medicare Advantage, please include a copy of the CMS Registry enrollment that includes submission number
  - APoE ε4 test results (if applicable)

**PRE-MEDS**

Acetaminophen (Tylenol®) 500 mg PO prior to infusion

Decadron (dexamethasone) 10 mg IV Push over 5 min.

Please instruct patient to take acetaminophen 650 mg every 6 hours routinely for the next 24 hours while at home.

**NURSING ORDERS**

Vitals prior to infusion If SBP ≥ 150 mmHg, hold treatment and call provider.

Vitals following infusion and prior to discharge

Patients to be monitored for 30 min following their infusion

Call prescriber and/or 911 for any hypersensitivity reactions including but not limited to fever, flu-like symptoms, nausea, vomiting, hypertension, and oxygen desaturation

Date of last infusion if not at BAMF Health: \_\_\_\_\_ RX Expiration Date: \_\_\_\_\_

**THERAPY ADMINISTRATION Cycle 1 – 3**

**Drug:** Kisunla 350mg/20 mL IVPB over 30 min. **Dose:** 700 mg **Frequency:** Q 4 Wks. **Cycle:** 1, 2, 3

**THERAPY ADMINISTRATION Cycle 4-7**

**Drug:** Kisunla 350mg/20 mL IVPB over 30 min. **Dose:** 1400 mg **Frequency:** Q 4 Wks. **Cycle:** 4, 5, 6, 7

**FOLLOW UP MR BRAIN w/o contrast** (Please use checkboxes below for allowing BAMF Health Nurse navigators to coordinate follow up MRIs at BAMF Health)

Rule Out:  Amyloid related imaging abnormalities (Brain Edema or Hemorrhage)  Other: \_\_\_\_\_

Order:  MR Brain w/o contrast (prior to 2<sup>nd</sup> Kisunla infusion)  MR Brain w/o contrast (prior to 4<sup>th</sup> Kisunla infusion)

MR Brain w/o contrast (prior to 3<sup>rd</sup> Kisunla infusion)  MR Brain w/o contrast (prior to 7<sup>th</sup> Kisunla infusion)

**Additional Orders: By signing this order, you agree to the following orders, unless otherwise noted.**

- Hold infusion and notify provider if patient reports: Headache, Dizziness, Nausea, Vision Changes, New or Worsening Confusion.
- May initiate IV catheter patency protocol
- Infusion/allergic reactions may be managed per facility protocol.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_