Hy-Vee health INFUSION CARE

KISUNLA
Referral Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Address: _____ **Patient Email:** _____

☐ NKDA Allergies: _____ **Weight (lbs/kg):** _____ **Height:** _____

ICD-10 Code (required): _____ **ICD-10 Description:** _____ **Last Treatment Date:** _____ **Last 4 SSN:** _____

Provider Information

Referral Coordinator Name: _____ **Referral Coordinator Email:** _____

Ordering Provider: _____ **Referring Practice Name:** _____

Practice Address: _____ **City:** _____ **State:** _____ **Zip:** _____

PREMEDICATIONS

☐ Acetaminophen (Tylenol) ☐ 500 mg / ☐ 650 mg / ☐ 1000 mg PO
☐ Loratadine (Claritin) 10 mg PO
☐ Diphenhydramine (Benadryl) ☐ 25 mg / ☐ 50 mg / ☐ PO / ☐ IVP
☐ Methylprednisolone (Solu-Medrol) ☐ 40 mg / ☐ 125 mg IVP
☐ Hydrocortisone (Solu-Cortef) ☐ 100 mg IVP
☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

REQUIRED DOCUMENTATION

☐ Clinical notes with amyloid beta confirmation
☐ Recent brain MRI prior to initiating treatment
☐ APOe4 results
☐ Prior to 14th Dose

KISUNLA ORDERS

DOSING:

☐ 700mg every 4 weeks for infusions 1, 2 and 3
☐ 1400mg every 4 weeks for infusion 4 and beyond

MONITORING:

☐ MRI prior to 2nd, 3rd, 4th and 7th infusion

CMS REQUIREMENT:

☐ MoCA (or other cognitive test) score: _____
☐ FAQ (or other functional test) score: _____

REFILLS:

☐ _____

(if not indicated prescription will expire one year from date signed)

REQUIRED DOCUMENTATION:

****Patient must be registered with CMS priror to treatment https://qualitynet.cms.gov/alzheimers-ced-registry****

Not applicable for patients with commercial insurance.

☐ Progress Notes Supporting DX
☐ Cognitive Assessment Score _____
☐ Confirmed Presence of Amyloid Pathology (*+CSF or Amyloid PET Scan*)

☐ CMS Registry Number _____

APOE Status ☐ Mild ☐ Moderate

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM