

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICD 10 CODE		
<input type="checkbox"/> Alzheimer's Disease with Early Onset	ICD 10 Code: G30.0	
<input type="checkbox"/> Alzheimer's Disease with Late Onset	ICD 10 Code: G30.1	
<input type="checkbox"/> Other Alzheimer's Disease	ICD 10 Code: G30.8	
<input type="checkbox"/> Alzheimer's Disease, unspecified	ICD 10 Code: G30.9	
<input type="checkbox"/> Mild Cognitive Impairment, of uncertain or unknown etiology	ICD 10 Code: G31.84 (must use in addition to above codes)	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> Baseline MRI within 1 year
<input type="checkbox"/> Beta Amyloid Pathology Confirmed via: <input type="checkbox"/> Amyloid PET Scan Date: _____ Results: _____ Or <input type="checkbox"/> CFS Analysis Date: _____ Results: _____ Or <input type="checkbox"/> Blood Plasma Date: _____ Results: _____ <input type="checkbox"/> Cognitive Assessment Used: _____ Date: _____ Results: _____ <input type="checkbox"/> ApoE Genetic Test: Date: _____ Results: _____ <input type="checkbox"/> Omozygote <input type="checkbox"/> Heterozygote <input type="checkbox"/> Non Carrier <input type="checkbox"/> Completion of CMS approved CED registry: CED Submission Date: _____ Submission Number: _____ <input type="checkbox"/> MRI of brain for ARIA monitoring prior to infusion <input type="checkbox"/> 2, <input type="checkbox"/> 3, <input type="checkbox"/> 4, and <input type="checkbox"/> 7, and if symptoms consistent with ARIA occur.		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders		
Initial Dosing	<input type="checkbox"/> J0175 Kisunla 700mg IV once every 4 weeks for infusions 1, 2, and 3	
Maintenance Dosing	<input type="checkbox"/> J0175 Kisunla 1400mg IV once every 4 weeks thereafter	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen 500mg PO PRN	<input type="checkbox"/> CBC	Date: _____
<input type="checkbox"/> Benadryl 25mg PO or IV	<input type="checkbox"/> CMP	Date: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Date: _____
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name: _____		
Office Phone: _____	Office Fax: _____	Office Email: _____
Prescriber Signature: _____	Date: _____	Time: _____

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – KISUNLA (DONANEMAB-AZBT)