Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Kisunla Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 attn: Idyllic Infusion Coordinator

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Insurance(s): include copies of front and back	
Preferred Treatment Location	❒ Voorhees ❒ Moorestown ❒ Wall/Manasquan ❒ Sewell ❒ Hamilton ❒ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

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Name (last, first) _____DOB: _____

Diagnosis:
❒ G30.0 Alzheimer's disease with early onset
❒ G30.1 Alzheimer's disease with late onset
❒ G30.8 Other Alzheimer's disease
❒ G30.9 Alzheimer's disease, unspecified
❒ G31.84 Mild cognitive impairment
❒ Other: _____

The following information is required:

The prescriber must indicate the following requirements have been met to confirm the diagnosis and that the patient has evidence of AD neuropathology and has been assessed for baseline ARIA risk via MRI:

- Amyloid pathology confirmed via:
  ❒ Amyloid PET Scan ❒ CSF analysis ❒ Blood plasma
  Date:_____
  Result: ❒ Amyloid Positive ❒ Amyloid Negative
  (Kisunla™ is not a treatment option for this Patient, if checked)

- Recent MRI obtained before initiating Kisunla™ (including FLAIR and T2/GRE or SWI) to assess ARIA risk:
  ❒ The prescriber has verified that this Patient does not have evidence of prior ARIA-H
  Date:_____

- Completion of cognitive assessment type:
  ❒ MMSE ❒ MoCA ❒ CDR ❒ Other:_____
  Date:_____

- Completion of functional assessment type:
  ❒ FAQ ❒ FAST ❒ Other
  Date:_____

❒ Completion of CMS-approved CED registry (only required for Patients with Medicare)
ClinicalTrials.gov Registry Number: NCT: _____
CED Submission Date:_____
Submission Number (if applicable):_____

Note: MRIs must be obtained before initial infusion to assess ARIA risk. During treatment, conduct an ARIA monitoring MRI before Infusions 2, 3, 4, and 7 and if symptoms consistent with ARIA occur.

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
    - ** NOTE ** Please DO NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- Include recent chart notes, scans, tests, labs to support the start of KISUNLA.
- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if the medication is discontinued.

Ordering Provider Signature: _____