BAMF Health Theranostics Center • Molecular Therapy Clinic
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bamfhealth.com

Kisunla Order

Revision 06.23.2026

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 (if applicable)

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 Early Onset (ICD-10 code: G30.0)
☐ Other: _____
☐ Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)
☐ Mild dementia due to Alzheimer's Disease (ICD-10 code: G30.9)
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) _____ ☐ MOCA _____
☐ 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®) 650 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 completion of 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: _____ (Rx expires in 12 months)

THERAPY ADMINISTRATION

☐ Cycle 1: Kisunla 350mg/20mL. Administer 350mg in 50mL 0.9% NS IVPB over 30 minutes
☐ Cycle 2: Kisunla 350mg/20mL. Administer 700mg in 100mL 0.9% NS IVPB over 30 minutes
☐ Cycle 3: Kisunla 350mg/20mL. Administer 1050 mg in 200mL 0.9% NS IVPB over 30 minutes
☐ Cycles 4-18: Kisunla 350mg/20mL. Administer 1400 mg in 200mL 0.9% NS IVPB over 30 minutes
☐ Additional Cycles: _____ to _____ Kisunla 350mg/20mL. Administer 1400 mg in 200mL 0.9% NS IVPB over 30 minutes
Administer cycles 4 weeks apart

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 2nd Kisunla infusion)	☐ MR Brain w/o contrast (prior to 4th Kisunla infusion)
	☐ MR Brain w/o contrast (prior to 3rd Kisunla infusion)	☐ MR Brain w/o contrast (prior to 7th 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: _____