

**Texas Centers for Infectious Disease Associates Pharmacy**

FORT WORTH / 1025 College Ave., Fort Worth, TX 76104

Email : [tcidaintake@tcida.net](mailto:tcidaintake@tcida.net)**Phone: 817-336-1640      Fax: 817-336-1643**

DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246



<b>Patient Information</b>			<b>Prescriber Information</b>		
Patient name:			Prescriber name:		
DOB:		SSN:	DEA:		
Address:			NPI		License:
City:		State:	Zip:		Address:
Phone #:			City:		State: Zip:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			Phone: Fax:		
<b>Insurance Information: Complete entirely and fax front and back of patient's insurance card</b>					
Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:
<b>ICD 10 and Diagnosis:</b>			<b>Patient History</b>		
ICD 10:			Weight <input type="checkbox"/> KG <input type="checkbox"/> LB		Height <input type="checkbox"/> IN <input type="checkbox"/> CM
Diagnosis:			<input type="checkbox"/> NKDA <input type="checkbox"/> Allergies:		Registry number: CED- _____
<b>Provider Orders:</b>					
MEDICATION	Drug	Dose	Route	Frequency	Therapy length
	<input type="checkbox"/> Kisunla	<input type="checkbox"/> Initial Dose: 350mg	IV	Q4 weeks	X 1
	<input type="checkbox"/> Kisunla	<input type="checkbox"/> Second Dose: 700mg <input type="checkbox"/> Third Dose: 1050mg <input type="checkbox"/> Maintenance Dose: 1400mg	IV	Q4 weeks	X 1 year
PRE-MEDICATION	<input type="checkbox"/> Acetaminophen 325 mg PO <input type="checkbox"/> Diphenhydramine 25 mg PO <input type="checkbox"/> Diphenhydramine 25 mg IV <input type="checkbox"/> Dexamethasone 4mg IVP <input type="checkbox"/> Methylprednisolone 40mg IVP <input type="checkbox"/> Other: _____				
<b>MRI</b>					
- Baseline brain MRI needed - Brain MRI must be provided prior to the 2 <sup>nd</sup> , 3 <sup>rd</sup> , 4 <sup>th</sup> and 7 <sup>th</sup> infusions.			<b>*Please fax or email MRI report with MRI approval document to 817-336-1643 prior to the 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> and 7<sup>th</sup> infusion *</b>		

**Nursing:** Evaluate and teach patient administration of IV ABX, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

**Prescriber Authorization:** I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IV antibiotics based on labs, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## MRI Approval Document

Patients Name:

Patients DOB:

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prior to the 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> and 7<sup>th</sup> infusion \*

☐ MRI Report

☐ MRI report reviewed and approval to infuse \_\_\_\_\_ insert infusion number} infusion

Prescriber signature:

Date:

## Referral check off

- **MD note**
  - ❖ Typical H&P with any pertinent information relating to the patient's diagnosis, condition and symptoms, if the patient has any history of ARIA (ARIA-E or ARIA-H)
- **Demographic sheet**
- **Last set of labs**
- **Confirmation of amyloid pathology**
  - ❖ Amyloid positron emission tomography (PET) scan
    - OR
  - ❖ Cerebrospinal fluid (CSF)
- **Cognitive assessment with a validated tool**
  - ❖ Clinical dementia rating (CDR) scale
    - OR
  - ❖ Mini-mental state exam (MMSE) score
    - OR
  - ❖ Montreal Cognitive assessment (MoCA)
- **Functional assessment with a validated tool**
  - ❖ The functional activities questionnaire (FAQ) score
- **Baseline MRI**
  - ❖ Subsequent MRI after 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> and 7<sup>th</sup> infusion
    - Each MRI will be faxed with MRI approval document