

Vermont  
28 Park Ave  
Suite #1A  
Williston, VT 05495



**KISUNLA™** (donanemab-azbt)

ORDER FORM

Date: \_\_\_\_\_

**PATIENT INFORMATION**

|               |                     |                                                            |
|---------------|---------------------|------------------------------------------------------------|
| Name:         | DOB:                | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| Phone Number: | Preferred Location: |                                                            |

**POVIDER INFORMATION**

|                    |                 |                           |
|--------------------|-----------------|---------------------------|
| Ordering Provider: | Practice Name:  |                           |
| Address:           | Office Contact: | NPI:                      |
| Phone:             | Fax:            | Contact email (required): |

**REFERRAL STATUS**(Check one)

☐ New Referral ☐ Referral Renewal ☐ Updated Order ☐ Transfer of care – Date of last infusion/Next due date

**Kisunla:**

Kisunla is indicated for the treatment of Alzheimer's disease (AD). Treatment with Kisunla should be initiated in patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in the clinical trials.

**Diagnosis ICD-10**

**Check one:**

- ☐ G31.84 Mild Cognitive Impairment, so stated  
☐ 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

**Premeds**

**Select all that apply:**

- ☐ Acetaminophen \_\_\_\_\_mg PO  
☐ Cetirizine 10mg PO  
☐ Diphenhydramine (check all that apply)  
\_\_\_\_\_25mg \_\_\_\_\_50mg \_\_\_\_\_PO \_\_\_\_\_IV  
☐ Methylprednisolone \_\_\_\_\_mg IV  
☐ Dexamethasone \_\_\_\_\_mg IV  
☐ Other:

**REQUIRED CLINICAL DOCUMENTATION CHECKLIST**

- \_\_\_\_ Demographics page with insurance info  
\_\_\_\_ Progress note with cognitive testing within the last 6 months  
\_\_\_\_ Amyloid PET scan or CSF results with amyloid confirmation  
\_\_\_\_ MRI of the brain within the last year  
\_\_\_\_ If Medicare patient, Alzheimer's Registry number  
(i.e. ALZH-00000)  
\_\_\_\_ Other

**Therapy Administration and Dosing** (supplied as 350mg/20mL vial)

All doses will be administered via appropriate final concentration of 4mg/mL to 10mg/mL

Dose #1 – 350mg IV – Administer in 0.9%NS IVPB over at least 30 minutes

Dose #2 – 750mg IV – Administer in 0.9%NS IVPB over at least 30 minutes

Dose #3 – 1050mg IV – Administer in 0.9%NS IVPB over at least 30 minutes

Doses #4-18 – 1400mg IV – Administer in 0.9%ND IVPB over at least 30 minutes

**Please indicate here any preferred variation from standard orders including longer infusion times, less doses, etc.**

• All patients will be kept for 30 minutes of monitoring following completion of infusion per the guidelines in the PI.

• Please note MRIs to assess for ARIA are required prior to doses 2, 3, 4 and 7 and must be sent to Thrivewell in order for patient to be cleared to proceed with treatment. Failure to provide the required MRI report at least 24hrs prior to the patient's scheduled appointment may result in delay in care for the patient.

**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, balance concerns, or change in mentation.
- Infusion/allergic reactions may be managed by clinical staff per facility protocol. Provider office will be notified in real time of any infusion reactions.

**NOTES/ADDITIONAL COMMENTS:**

ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_