

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



KISUNLA™ (donanemab-azbt)

ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
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 – 700mg 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 _____