

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



KISUNLA™ (donanemab-azbt) ORDER FORM

Date: _____

PATIENT INFORMATION

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

PROVIDER INFORMATION

Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Office Contact:	Address:
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

PATIENT WEIGHT

_____ lbs.
 _____ kg

Therapy Administration and Dosing (supplied as 350mg/20mL vial)
 All doses will be administered via appropriate final concentration of 4mg/mL to 10mg/mL

■ Premeds
Select all that apply:

Acetaminophen _____mg PO (recommended for first 6 doses)
 Cetirizine 10mg PO
 Diphenhydramine (check all that apply)
 ___25mg ___50mg ___PO ___IV
 Methylprednisolone _____mg IV
 SoluCortef _____mg IV
 Other: _____

Doses #1 – 350mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
 Doses #2 – 700mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
 Doses #3 – 1050mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
 Doses #4-18 – 1400mg IV – Administer in 0.9%NS IVPB over at least 30 minutes

REQUIRED CLINICAL DOCUMENTATION CHECKLIST:

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

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.

Provider Signature: _____ **Date:** _____

Notes/Additional Comments: _____