

**Borough Park**  
1428 36th Street  
Suite 107  
Brooklyn, NY 11218

**Forest Hills**  
64-05 Yellowstone Blvd  
CF104  
Forest Hills, NY 11375

**Sheepshead Bay**  
2546 East 17th Street  
Fl. 1  
Brooklyn, NY 11235

**Bronx**  
226 West 238th Street  
Bronx, NY 10463

**E 56th & Park Midtown**  
120 East 56 Street  
Suite 300  
New York, NY 10022

**FIDI**  
30 Broad Street  
Suite 401  
New York, NY 10004

**Gramercy**  
7 Gramercy Park West  
Lower Level  
New York, NY, 10003

**NYC**  
**E 70th St Upper East Side**  
225 E 70th Street  
Suite 1E  
New York, NY 10021

**Central Park West**  
115 Central Park West  
Suite 15  
New York, NY 10023

**ThrIVewell**  
**I N F U S I O N**  
Office: 212-803-3339 Fax : 646-768-8600

  
Mission Medical

**Tarrytown**  
555 Taxter Road  
3rd Floor  
Elmsford, NY 10523

**Port Jefferson**  
12 Medical Drive  
Suite B  
Port Jefferson Station, NY 11776

**Staten Island**  
27 New Dorp Lane  
Staten Island, NY 10306

**Southampton**  
625 Hampton Road  
Southampton, NY 11968

**Riverhead**  
1228 E Main Street  
Suite A  
Riverhead, NY 11901

**Holbrook**  
233 Union Avenue  
Suite 207  
Holbrook, NY 11741

**Manhasset**  
333 East Shore Road  
Suite 201  
Manhasset, NY 11030

**Rockville Centre**  
165 North Village Avenue  
Suite 133  
Rockville Center, NY 11570

**New Hyde Park**  
1991 Marcus Ave  
Suite 110  
Lake Success, NY, 11042

**Woodbury**  
7600 Jericho Tpke,  
Lower Level, Suite C500  
Woodbury NY 11797

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: <input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Updated Order <input type="checkbox"/> Transfer of care – Date of last infusion/Next due date	
<b>KISUNLA:</b> 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.	
<div><b>■ Diagnosis ICD-10</b> <b>Check one:</b> <input type="checkbox"/> G31.84 Mild Cognitive impairment, so stated <input type="checkbox"/> G30.0 Alzheimer’s Disease with early onset <input type="checkbox"/> G30.1 Alzheimer’s Disease with late onset <input type="checkbox"/> G30.8 Other Alzheimer’s Disease <input type="checkbox"/> G30.9 Alzheimer’s Disease, unspecified</div>	<div><b>PATIENT WEIGHT</b> _____ 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  <input type="checkbox"/> Doses #1 – 350mg IV – Administer in 0.9%NS IVPB over at least 30 minutes <input type="checkbox"/> Doses #2 – 700mg IV – Administer in 0.9%NS IVPB over at least 30 minutes <input type="checkbox"/> Doses #3 – 1050mg IV – Administer in 0.9%NS IVPB over at least 30 minutes <input type="checkbox"/> Doses #4-18 – 1400mg IV – Administer in 0.9%NS IVPB over at least 30 minutes</div>
<div><b>■ Premeds</b> <b>Select all that apply:</b> <input type="checkbox"/> Acetaminophen _____mg PO (recommended for first 6 doses) <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine (check all that apply) _____25mg _____50mg _____PO _____IV <input type="checkbox"/> Methylprednisolone _____mg IV <input type="checkbox"/> SoluCortef _____mg IV <input type="checkbox"/> Other: _____</div>	
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: \_\_\_\_\_