TN
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

KISUNLA™ (donanemab-azbt) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
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

■ **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: _____

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

- ☐ 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
- _____ Progress note with cognitive testing within the last 6 months
- _____ Patient's recent weight
- _____ 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)

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: _____