

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



KISUNLATM (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	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
■ 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: _____	
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: _____