Provider Order Form

KISUNLA (DONANEMAB-AZBT)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Baseline Brain MRI ☐ Cognitive assessment score
☐ Documented evidence of beta-amyloid plaque on the brain (PET, CSF, Lumbar, Blood test)

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Height: _____ Weight: _____ ☐ lbs ☐ kg

Address: _____ Email Address: _____

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Alzheimer's Disease G30.9
☐ Alzheimer's Disease G30.1
☐ Mild cognitive impairment G31.84
☐ Alzheimer's Disease G30.0
☐ Other Alzheimer's Disease G30.8

REGISTRY NUMBER – (required for patients with Medicare)

Registry Number: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Administer KISUNLA as an intravenous infusion over approximately 30 minutes every four weeks as follows

Medication	Dose	Frequency
☒ Kisunla (Donanemab-AZBT), IV	Infusion 1: 350 mg Infusion 2: 700 mg Infusion 3: 1,050 mg Infusion 4 and beyond: 1,400 mg.	☒ Every 4 weeks

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated.
☒ Infuse over 30 minutes.
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.
*Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____

SPECIAL INSTRUCTIONS

Provider Signature Date