

Provider Order Form
KISUNLA (DONANEMAB-AZBT)

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

REGISTRY NUMBER – (required for patients with Medicare)

Registry Number: _____ Registration Date: _____

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
☐ Cetirizine (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

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