Donanemab-azbt (Kisunla)

Provider Order Form rev. 07/25/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Alzheimer's Disease:

Other: Description:

REQUIRED INFORMATION FOR MEDICARE

☐ Z00.6: Encounter for examination for normal comparison and control in clinical research program

Medicare Trial Registry Number: _____

THERAPY ADMINISTRATION & DOSING

☐ Administer KisunlaIV over 30 minutes every 4 weeks: first dose 350mg IV, second dose 700mg IV, third dose 1050mg IV, fourth dose and beyond 1400mg IV.

☐ Administer Kisunla 1400mg IV over 30 minutes every 4 weeks.

☑ Flush the IV line with normal saline to make sure all medication is infused.

☑ Monitor patient for at least 30mins after each infusion

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- MRI not performed or read by radiologist. Baseline MRI within 1 year and repeat MRIs prior to 2nd, 3rd, 4th and 7th infusion.
- Signs of Amyloid Related Imaging Abnormalities (ARIA) as reported on MRI results.
- New neurological symptoms including headaches or altered mental status.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

☑ To report suspected adverse reactions, contact FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. Documentation confirming patient's enrollment in CMS National Patient Registry, Recent baseline MRI within 1 year and throughout treatment, PET or CSF analysis for amyloid bodies, cognitive function score

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.