Donanemab-azbt (Kisunla)

Provider Order Form rev. 10/15/2025

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

☑ I, the prescribing provider, acknowledge that I am responsible for ordering and reviewing all brain MRIs for this patient. By checking this box, I confirm that I will obtain and review all required MRIs prior to submitting results to Infusion Center. Infusion staff will proceed with the prescribed dose only after receiving the reviewed MRI.

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.