

KISUNLA (donanemab-azbt) Infusion Orders

Patient Name: _____ DOB: _____ M F

NKDA Allergies: _____

New Start therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

_____ Alzheimer's Disease

Z00.6 Required CMS Code

Pre-Medication:

- Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Cetirizine 10mg PO Solu-Cortef 100mg IVP
 Diphenhydramine 25mg PO Diphenhydramine 25mg IVP
 Other: _____

Required Documents:

- Patient Demographic Sheet
 Clinical/Progress notes supporting primary diagnosis *(please attach)*
 Brain MRI & Date *(must be w/in 1 year)*
 MoCA Score *(or another cognitive test)*
 FAQ Score *(or another functional test)*
 APOe4 results
 Patient enrolled in *CMS National Patient Registry* and ID# provided.

KISUNLA ORDERS:

Dosing & Frequency: Mix in 0.9% sodium chloride, administer IV over 30 minutes, with at least 30-minute post-infusion observation period

Infuse Kisunla every 4 weeks, 350mg for infusion 1, 700mg for infusion 2, 1050mg for infusion 3, and 1400mg for infusion 4 and beyond.

Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Monitoring: Ensure brain MRI obtained prior to 2nd, 3rd, 4th, and 7th infusions due to risk of ARIA.

Red River Health Standing Orders:

Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____