ALLIED INFUSION SERVICES

Kisunla (donanemab-azbt) Order

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

Patient Information

Name: ______________________
DOB: ______________________
Address: ______________________
City: ____________ State: ____________
Zip: ____________ Weight: ____________
Phone: ______________________
Allergies: ______________________

Prescriber Information

Prescriber Name: ______________________
NPI: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Phone: ______________________

Diagnosis (please provide ICD-10 code in space provided):

__________ Early onset Alzheimer's Disease - G30.0
__________ Late onset Alzheimer's Disease - G30.1
__________ Alzheimer's Disease unspecified - G30.9
__________ Mild Cognitive Impairment - G31.84
__________ Other: ______________________

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.
If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Premedications:

☐ Tylenol 650mg PO ☐ Loratadine 10mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol 40mg, 125mg or ____ mg
☐ Other: ______________________

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

Kisunla IV	☐ Initial Dose + Maintenance Dose: 700mg every four weeks for three doses and 1400mg every four weeks thereafter ☐ Initial Dose ONLY: 700mg every four weeks for three doses ☐ Maintenance Dose ONLY: 1400mg every four weeks Other: ______________________ Mixed in 0.9% Sodium Chloride. Use in-line, sterile, non-pyrogenic low protein binding filter (pore size 0.2 micron). Administer over a minimum of 30 minutes. Observe the patient for at least 30 minutes after the infusion for infusion related and hypersensitivity reactions. Obtain recent baseline brain MRI prior to initiating treatment. Repeat brain MRI MUST be obtained prior to infusion 2, 3, 4, and 7

Prescriber Name (Please print): ______________________
Prescriber Signature: ______________________ Date: ____________

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.