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	☐ **Induction ramp up: Week 0:** 350mg IV infusion, **Week 4:** 700mg IV infusion, **Week 8:** 1050mg IV infusion ☐ **Maintenance: Week 12 and every 4 weeks thereafter:** 1400mg IV infusion ☐ 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. If missed dose, administer the same dose as soon as possible and continue every 4 weeks. 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.