Kisunla (donanemab-azbt)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:		Next Due Date:

DIAGNOSIS AND ICD 10 CODE	
☐ G30.0 Alzheimer's disease with early onset	☐ G30.9 Alzheimer's disease, unspecified
☐ G30.1 Alzheimer's disease with late onset	☐ G31.84 Mild cognitive impairment, so stated
☐ G30.8 Other Alzheimer's disease	

REQUIRED DOCUMENTATION

☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes

Prescriber must indicate the following requirements have been met to confirm diagnosis and that Patient has evidence of AD neuropathology and has been assessed for baseline ARIA risk via MRI (*provide supporting documentation*)

☐ **Amyloid pathology confirmed via:** (Kisunla is not a treatment option for this Pt, if checked)

AND ➡ ☐ Amyloid PET Scan **OR** ☐ CSF analysis **OR** ☐ Blood plasma Date: _____Result**:** ☐ Amyloid Positive ☐ Amyloid Negative ⤴

☐ **Recent MRI obtained prior to initiating Kisunla (including FLAIR and T2/GRE or SWI) to assess ARIA risk**

AND ➡ ☐Prescriber has verified that this Patient does not have evidence of prior ARIA-H **Date**:_____

☐ **Completion of cognitive assessment type:**

AND ➡ ☐MMSE ☐MoCA ☐CDR ☐Other **Date:**_____

☐ **Completion of functional assessment type:**

AND ➡ ☐FAQ ☐FAST ☐Other **Date**: _____

☐**Completion of CMS approved CED registry (only required for Patients with Medicare)**

ClinicalTrials.gov Registry Number: NCT _____

CED Submission Date: _____ Submission Number (if applicable): _____

Note: MRIs must be obtained prior to initial infusion to assess ARIA risk. During treatment, conduct an ARIA monitoring MRI before Infusions 2, 3, 4 and 7 and if symptoms consistent with ARIA occur.

MEDICATION ORDERS	
Initial dosing	☐ Kisunla 700 mg IV every 4 weeks x 3 doses
Maintenance dosing	☐ Kisunla 1400 mg IV every 4 weeks

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

**(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

PRESCRIBER INFORMATION		
Provider Name (print)	Provider Signature*:	Date:
Office Phone	Office Fax	

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

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