

# Kisunla (donanemab-azbt)



REFERRAL STATUS:  New Referral  Dose or Frequency Change  Order Renewal  
Infusion Office Preference: \_\_\_\_\_

### PATIENT INFORMATION

|  |                    |         |
|--|--------------------|---------|
| Date:  | Patient Name:      | DOB:    |
| <input type="checkbox"/> NKDA Allergies:   | Weight (lbs / kg): | Height: |
| Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date: | Next Due Date:     |         |

### DIAGNOSIS AND ICD 10 CODE – please choose one G code from the items below, automatic secondary will be added

- |  |  |
|--|--|
| <input type="checkbox"/> <b>G30.0</b> Alzheimer's disease with early onset<br><input type="checkbox"/> <b>G30.1</b> Alzheimer's disease with late onset<br><input type="checkbox"/> <b>G30.8</b> Other Alzheimer's disease | <input type="checkbox"/> <b>G30.9</b> Alzheimer's disease, unspecified<br><input type="checkbox"/> <b>G31.84</b> Mild cognitive impairment, so stated<br><b>Secondary</b> <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Z00.6</b> Encounter for examination for normal comparison and control in clinical research program</li></ul> |
|--|--|

### 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)  
➔  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**  
➔  Prescriber has verified that this Patient does not have evidence of prior ARIA-H Date: \_\_\_\_\_
- Completion of cognitive assessment type:**  
➔  MMSE  MoCA  CDR  Other Date: \_\_\_\_\_
- Completion of functional assessment type:**  
➔  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

|   |  |
|---|--|
| <b>Initial dosing</b>   | <input type="checkbox"/> Kisunla 700 mg IV every 4 weeks x 3 doses |
| <b>Maintenance dosing</b>   | <input type="checkbox"/> Kisunla 1400 mg IV every 4 weeks          |
| Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> 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](mailto:bionurses@metroinfusioncenter.com)**

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