KISUNLA ORDERS (DONANEMAB)

PATIENT INFORMATION		PRESCRIBER INFORMATION
Patient Name: _____		Prescriber Name: _____
Address: _____		NPI: _____
City, State, Zip: _____		Address: _____
Cell: _____	Email _____	City, State, Zip: _____
Height _____ Weight _____ Last 4 of SSN: _____ DOB: _____		Phone: _____ Fax: _____
Allergies: _____		Contact Person: _____

REFERRAL STATUS	
☐ New Referral	☐ Is this the first Dose? Yes/No
☐ Dose or Frequency Change	☐ If no, date of last infusion
☐ Continuation Order	Line type: ☐PIV ☐PICC ☐Port ☐Other

DIAGNOSIS	
☐ G30.0 Alzheimer's disease with early onset	Z00.6 Encounter for examination for normal comparison and control in clinical research program
☐ G30.1 Alzheimer's disease late onset	☐ F02.80 Dementia without behavioral disturbance
☐ G30.8 Other Alzheimer's disease	☐ F02.81 Dementia with behavioral disturbance
☐ G30.9 Alzheimer's disease, unspecified	☐ G31.84 Mild Cognitive Impairment due to Alzheimer's Disease

REQUIRED DOCUMENTATION	
• This signed order form by the provider • Patient demographics and insurance information • H&P, labs, tests, and progress notes supporting diagnosis	☐ Medicare beneficiaries: NCT registry number: _____ ☐ Date of brain MRI negative for ARIA: _____ ☐ Documentation of amyloid beta pathology by PET scan, CSF sample, or Plasma sample
SUBSEQUENT BRAIN MRI AND WRITTEN APPROVAL FROM ORDERING PROVIDER MUST BE OBTAINED PRIOR TO INFUSING 2ND, 3RD, 4TH, AND 7TH INFUSION.	

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
☐ Donanemab-azbt (Kisunla)	350 mg/20 mL	☐ New Start Infuse IV in 0.9% NS for final concentration of 4mg/ml to 10mg/ml over 30 minutes every 4 weeks as follows • Infusion 1, Infuse 350 mg x 1 dose • Infusion 2, Infuse 700 mg x 1 dose (hold for MRI results) • Infusion 3, Infuse 1050 mg x 1 dose (hold for MRI results)	6 vials
		☐ Maintenance Infusions 4-18, Infuse 1400 mg IV in 0.9% NS for final concentration of 4mg/ml to 10mg/ml over 30 minutes every 4 weeks (hold infusions 4 and 7 for MRI results)	4 vials Refill x 11
Observation		Observe patient for a minimum of 30 minutes post infusion	
☐ Acetaminophen	650 mg	650 mg po prior to infusion	
☐ Diphenhydramine	25 mg	25 mg po prior to infusion	

For PIV flush 3-10 mL 0.9% NS before and after
For PICC/Midline flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush
For Port flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush
Using 50 ml 0.9% NS bag flush residual priming volume post infusion

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
RN to flush and lock VAD/CVAD per company protocol
Other:_____

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____ X: _____
Product Substitution Permitted: ☐ Date: _____ Dispense as Written: ☐ Date: _____

Print, complete, and fax completed form to: (855) 857-3834