DONANEMAB ORDERS (Kisunla)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ ApoE εe4 Genetic test
☐ Amyloid beta pathology by PET scan, CSF/Plasma sample, Brain MRI with negative ARIA result
☐ Medicare registry number if applicable
☐ Ensure patient has arrangements for MRIs at the appropriate intervals for treatment
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

DONANEMAB ORDERS (Kisunla)

CENTERS AT SIC
An Access Infusion Care Managed Company

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

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS
☒ Dx Code: Z00.6 Encounter for examination for normal comparison and control in comparison and control in clinical research program
☐ Secondary Dx Code/description:
☐ Other Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx	
Prior Therapies:	☐ Brain MRI with negative ARIA result-Date:
☐ ApoE ε4 Genetic test-Date: Result: ☐ Homozygote	☐ Heterozygote ☐ Noncarrier
☐ Amyloid beta pathology by PET scan, CSF/Plasma sample	☐ Medicare Beneficiaries- NCT Registry #:
Brain MRI results and written approval from referring provider must be obtained prior to 2nd,3rd,4th, and 7th infusion	

PRESCRIBING INFORMATION

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Donanemab (Kisunla)**	350mg/20mL	☐ **Induction Dosing**- Infuse every 4 weeks: Infusion 1: 350 mg x 1 dose Infusion 2: 700 mg x 1 dose (hold for MRI results) Infusion 3: 1050 mg x 1 dose (hold for MRI results)	6 vials Refills: none
		Maintenance Dosing- Infuse every 4 weeks (hold infusions 4 and 7 for MRI results): ☐ **Infusions 4-12: 1400mg** ☐ **Infusions 13-18: 1400mg**	4 vials Refills:
		Infuse IV in 0.9%NS for final concentration of 4mg/ml-10mg/ml over 30 minutes	

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION: Observe the patient for at least 30 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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