Fax: 832-895-4040
Phone: 832-895-5000
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adaptIV infusion

Kisunla™ (donanemab-azbt)

Provider Order Form rev. 8/10/2024

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Medicare Registry # _____

DIAGNOSIS:
☐ G30.0 Alzheimer's Disease, Early Onset
☐ G30.1 Alzheimer's Disease, Late Onset
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild Cognitive Impairment, So Stated
G30.X codes require secondary F02.8X code BELOW:
☐ F02.80 Dementia without behavioral disturbance
☐ F02.81 Dementia with behavioral disturbance

PRESCRIBER MUST INDICATE THE FOLLOWING REQUIREMENTS HAVE BEEN MET (PLEASE PROVIDE DOCUMENTATION):
☐ Obtain a recent baseline brain magnetic resonance imaging (MRI) prior to initiating treatment with KISUNLA.
☐ Beta Amyloid Pathology Confirmed Via:
☐ Amyloid PET Scan Date: _____
OR
☐ CSF Analysis Date: _____ Result: _____
Completion of cognitive assessment: ☐ MMSE ☐ MoCA ☐ CDR
☐ Other _____ Date: _____
Completion of functional assessment type: ☐ FAQ ☐ FAST
☐ Other _____ Date: _____

PRE-INFUSION:
☐ Confirm baseline MRI results prior to initiation of treatment.
☐ Confirm MRI completed and reviewed by prescriber prior to 2nd, 3rd, 4th, and 7th infusions.
☐ Hold infusion and notify provider if patient reports:
- Headache
- Vision changes
- Dizziness
- New or worsening confusion
- Nausea

TREATMENT FREQUENCY:
☐ Schedule treatments every 28 days/monthly/every 4 weeks.

DOSE
☐ 700mg infusions 1,2, and 3
☐ 1400mg infusion 4 and beyond

MEDICATION:
☐ Administer KISUNLA over approximately 30 minutes
☐ If infusion-related reaction occurs, stop infusion and treat per orders/ protocol as clinically indicated.

POST-INFUSION:
☐ Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion.
☐ Fax treatment notes to provider at number below.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK