

# KISUNLA (DONANEMAB-AZBT) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 CMS Registry # \_\_\_\_\_ (Medicare only)  
 ALZ-Net # \_\_\_\_\_ (All other commercial payors/approved alz-net providers only)  
 Patient has known difficult venous access. Comments: \_\_\_\_\_  
 New Start Therapy |  Continuation of Therapy & Date of last dose (if applicable): \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

Alzheimer's Disease, ICD 10: G30.9       Alzheimer's Disease with Late Onset, ICD 10: G30.1  
 Alzheimer's Disease with Early Onset, ICD 10: G30.0       Other Alzheimer's Disease, ICD 10: G30.8

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

Demographics     Labs and tests supporting diagnosis     Office/progress notes

## PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV       Methylprednisolonep  
 Benadryl 25mg PO       Cetirizine (Zyrtec) 10 mg PO      (Solu-Medrol) 125 mg IVP  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Kisunla	Day 1 350mg; Day 2 (4 wks later) 700mg; Day 3 (4 wks later) 1050mg; Day 4 and every 4 wks 1400mg	IV	every 4 weeks (after initial x3 step dosing infusions)

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

CT: 203.433.0621  
 FL: 904.877.9270

MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

SC: 864.973.6279  
 VA: 703.202.0499