immersiv HEALTH

KISUNLA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild cognitive impairment, so stated

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information
☐ List of Medications
☐ Most Recent History & Physical
☐ Tried & Failed Therapies
☐ Cognitive Assessment & Score
☐ Functional Assessment & Score
☐ Confirmed Amyloid Pathology
☐ Recent MRI prior to initiating Kisunla
☐ Proof of CED registry submission

MEDICATION ORDER

***Referring provider responsible for obtaining MRI prior to infusion #2, #3, #4 and #7 for monitoring of ARIA**

☐ **LOADING:** Kisunla® (donanemab) 350 mg IV in 50 ml NS over 30 minutes at week 0; 700 mg IV in 100 ml NS over 30 minutes at week 4; 1,050 mg IV in 100 ml NS over 30 minutes at week 8.

☐ **MAINTENANCE:** Kisunla® (donanemab) 1,400 mg IV in 250 ml NS over 30 minutes every 4 weeks

*Maintenance dosing scheduled 4 weeks from last loading dose (week 8 dose)

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following each administration. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO
☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV
☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN