Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Location

☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Kisunla (donanemab-azbt)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Secondary Diagnosis and ICD 10 Code (Required)

Primary ICD 10 Code will be Z00.6 Encounter for examination for normal comparison and control in clinical research program.

☐ Alzheimer's Disease with Early Onset ICD 10 Code: G30.0
☐ Alzheimer's Disease with Late Onset ICD 10 Code: G30.1
☐ MCI due to AD ICD 10 Code: G31.84
☐ Other Alzheimer's Disease ICD 10 Code: G30.8
☐ Alzheimer's Disease Unspecified ICD 10 Code: G30.9

Required Labs

ApoE E4 status
Most recent CBC & CMP (attach results)

Required Test

MRI's should be performed at baseline & prior to the 2nd, 3rd, 4th, and 7th infusion.

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: _____ Route: _____
Dose: _____ Frequency: _____

Kisunla Medication Order

Refill x12 months unless otherwise noted:

Refills: 2- 700mg dose
8-1400 mg dose

700 mg IV every 4 weeks for 3 doses then

1400mg IV every 4 weeks.

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Cognitive Assessment Score _____
☐ MRI of the Brain within 1 year
☐ Confirmed presence of amyloid pathology (Amyloid PET scan or +CSF)
☐ CMS National Patient Registry # _____

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____