

## Kisunla (Donanemab-azbt) Infusion Order

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code): \_\_\_\_\_

Other: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_

New Therapy Order  Continuation of Therapy Date of last dose: \_\_\_\_\_

Ordering Provider Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Pre-Medication

- Acetaminophen \_\_\_\_\_mg by  PO
- Cetirizine \_\_\_\_\_mg by  PO
- Diphenhydramine \_\_\_\_\_mg by  PO/  IVP
- Solu-Medrol \_\_\_\_\_mg by  PO/  IVP
- Solu-Cortef \_\_\_\_\_mg by  PO/  IVP
- Other: \_\_\_\_\_

### Patient Height and Weight:

Patient Height (cm): \_\_\_\_\_

Patient Weight (kg): \_\_\_\_\_

### Required Documentation:

- Patient Medicare Registry # \_\_\_\_\_
- Copy of Patient Medicare Registry Confirmation Email
  - Must include the registration date, and the doctor's signature
- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Clinical notes with amyloid beta confirmation
- MRI prior to the start of 1st infusion
- Amyloid-presence verified with either a PET Scan or CSF analysis
- MMSE Test Results
- Lilly Patient Copay Assistance Application as needed
- Other: \_\_\_\_\_

### Kisunla Medication Order (Please select ONE):

- 350mg IV every 4 weeks for treatment 1. **Please be advised that an MRI is required prior to 1st infusion**
- 700mg IV every 4 weeks for treatment 2. **Please be advised that an MRI is required prior to 2nd infusion**
- 1050mg IV every 4 weeks for treatment 3. **Please be advised that an MRI is required prior to 3rd infusion**
- 1400mg IV every 4 weeks for treatments 4 and thereafter. **Please be advised that an MRI is required prior to 4th and 7th infusions**
- 1400mg IV every 4 weeks for treatments \_\_\_\_\_

**Additional Instructions/Notes:**

  
  
  
  

### Ordering Provider:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_

Phone: \_\_\_\_\_

### Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400