Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

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
□ Other:

Kisunla Medication Order (Please select ONE):

□ 700mg IV every 4 weeks for treatments 1-3. **Please be advised that an MRI is required prior to 1st, 2nd and 3rd infusion**

□ 1400mg IV every 4 weeks for treatments 4-6. **Please be advised that an MRI is required prior to the 4th infusion**

□ 1400mg IV every 4 weeks for treatments 7-12. **Please be advised that an MRI is required prior to the 7th infusion**

□ 1400mg IV every 4 weeks for treatments 13-18.

□ 1400mg IV every 4 weeks for treatments _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Updated: 10/24/2024