Local Infusion

MYLOCALINFUSION.COM

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 (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO

❑ Cetirizine (Zyrtec) 10 mg PO

❑ 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 ❑ Maintenance 1400mg:	IV	❑ every 4 weeks (after initial x3 step dosing infusions) ❑ every 4 weeks

LABS / SPECIAL INSTRUCTIONS