# KISUNLA
(donanemab-azbt)

FLEXCARE INFUSION CENTERS

## PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | Patient's Email: |

## REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Medication List • Tried/Failed Therapies • Most Recent Labs
• MRI within 1 year • Amyloid Pathology Confirmation • Cognitive Assessment & Score • Functional Assessment & Score

• Registry #_____

## PRIMARY AND SECONDARY DIAGNOSIS

**Primary Diagnosis:**
☑ Z00.6 Encounter for examination for normal comparison and control in clinical research program

**Secondary Diagnosis:**
☐ 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

☐ Other: _____

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen 650mg, cetirizine or loratadine 10mg PO before each dose
☐ Provider Prescribed: _____

## PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions
☐ Kisunla 350mg IV at Week 0, 700mg IV at Week 4, 1050mg IV at Week 8, followed by 1400mg IV every 4 weeks thereafter
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact: |
| Address: | Phone: |
| City, State, Zip: | ☐ Fax: |
| NPI **AND** License: | ☐ Email: |

_____ _____
Provider Signature Date

**FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals**