KISUNLA

(Donanemab-azbt) Infusion Order

NobleInfusion

Phone: 386-957-9600
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PATIENT INFORMATION:

Patient Name: _____ ☐ Male ☐ Female
DOB: _____ Phone number: _____
Allergies: ☐ NKDA ☐ allergic to _____
☐ start new treatment ☐ continue treatment. ____ dose/s already complete. Date of last dose: _____

Height: _____ Weight:_____

CMS Submission #: _____

DIAGNOSIS:

☐ G30.0- AD w/ early onset ☐ G30.1- AD w/ late onset ☐ G30.8- other AD ☐ G30.9- AD unspecified
☐ G31.84- MCI, so stated

PREMEDICATION & HYDRATION:

☐ Diphenhydramine 25 mg IVP **OR** Diphenhydramine 25 mg PO **OR** Citirizine 10 mg PO
☐ acetaminophen 1000 mg PO ☐ Solu Medrol 125 mg IVP ☐ 500 ml hydration over 30 minutes

REQUIRED TESTING/LABS

*MRI prior to initiating treatment AND prior to 2nd, 3rd, 4th, and 7th infusion	*Clinical notes with amyloid beta confirmation
*PET Scan	*APOe3 testing- optional
*Patients last visit note	*MoCA or MMSE

KISUNLA DOSING:

☐ 350 mg at infusion #1, 700 mg for infusion #2, 1050 for infusion #3 ☐ 1400 mg every 4 weeks for infusion #4 and beyond

★ Patient takes anticoagulants and provider has approved Kisunla treatment ☐ yes ☐ no

★ If yes, has provider discussed risk of ARIA with patient ☐ yes ☐ no

ORDERING PROVIDER:

Name: _____ NPI _____
Phone: _____ fax: _____
Practice Address: _____
City: _____ State: _____ Zip: _____

Provider Signature_____ Date: _____