RESTORE HEALTH
INFUSION AND WELLNESS

KISUNLA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs, Diagnostic Testing

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB**: _____ **Gender**: ☐M ☐F ☐Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

For Medicare Recipients: CMS Registry Number: _____ Clinical trial Number: NCT _____

If the patient is enrolled in the CMS National Patient Registry, please use NCT 06058234. If the patient is enrolled in a different CMS-approved CED registry, please use the assigned Clinicaltrials.gov number as appropriate. All Medicare patients must be enrolled in a qualifying study and will not be scheduled if information is not provided

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

Diagnosis: ☐G30.0 (Alzheimer's disease with early onset) ☐G30.1 (Alzhemier's disease with late onset)
☐G30.8 (Other AD) ☐G30.9 (AD, unspecified) ☐Z00.6 (+ AD Code for CMS Billing) ☐Other: _____

Allergies: _____ **Weight:** _____ ☐Kg ☐Lbs **Height:** _____ ☐cm ☐in

Amyloid Confirmation: ☐PET ☐CSF **ARIA History:** ☐Yes ☐No

MRI Completed (Baseline + Prior to 2nd, 3rd, 4th, 7th Infusion Required): ☐Yes ☐No

Please attach results to referral

TREATMENT INFORMATION

KISUNLA (donanemab-azbt)

Route: Intravenous infusion

Dose: ☐Initial Doses
Infusion 1: 350mg
Infusion 2: 700mg
Infusion 3: 1040mg
☐Infusion 4+: 1400mg

Frequency:
☐Every 4 weeks

Quantity: _____ **Refills:** _____

Premedication Protocol:

☐ Diphenhydramine: ☐25mg ☐50mg ☐PO ☐IV
☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO
☐ Methylprednisolone: ☐40mg ☐125mg IV
☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____