

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 (Alzheimer'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:** _____

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