

# Kisunla™ (donanemab-azbt) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

**Fax completed form, insurance information and clinical documentation to 414-260-7368.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Height: \_\_\_\_\_  inches  cm Weight: \_\_\_\_\_  lbs  kg

New Therapy  Continuing Therapy Last Therapy Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## Clinical Information

Primary ICD 10 code Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis and ICD 10 code (Required)

Alzheimer's Disease with late onset ICD 10 code: G30.1

Other Alzheimer's Disease ICD 10 code: G30.8

Alzheimer's Disease, unspecified ICD 10 code: G30.9

MCI due to AD ICD 10 code: G31.84

Alzheimer's Disease with early onset ICD 10 code: G30.0

## Kisunla Prescription

Dose 1 - 350 mg IV at week 0

Dose 2 - 700 mg IV at week 4

Dose 3 - 1050 mg IV at week 8

1400 mg IV at week 12 and every 4 weeks thereafter

Administer all infusions IV over 30 minutes with a 30-minute post-observation time.

Refill every 12 months unless otherwise noted.

## Ancillary Orders

### Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

**Pre-medications Orders**  Acetaminophen (Tylenol)  500 mg /  650 mg /  1000 mg

Loratadine (Claritin) 10 mg PO

Hydrocortisone (Solu-Cortef)  100 mg IVP

Diphenhydramine (Benadryl)  25 mg/  50 mg/  PO/  IVP

Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

**IV Access and Flush Orders:** RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

### Lab Orders

No labs ordered at this time.

Other: \_\_\_\_\_

CMS requirement:  MoCA (or other cognitive test) score: \_\_\_\_\_  FAQ (or other functional test) score: \_\_\_\_\_

MRI prior to infusions 2, 3, 4, and 7

## Required Documentation

Clinical notes with amyloid beta confirmation

Recent brain MRI prior to initiating treatment

APOe4 results

**I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.**

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ NPI \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Office Contact \_\_\_\_\_



Original - Medical Records

**Froedtert Home and Specialty Infusion**  
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