Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Kisunla Order Form

Patient Name: _____ DOB:_____

Phone:_____ Address: _____

City: _____ State:_____ Zip:_____ Email: _____

Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Alzheimer's Disease with Early Onset ICD-10: G30.0
- ☐ Alzheimer's Disease with Late Onset ICD-10: G30.1
- ☐ Alzheimer's Disease, Unspecified ICD-10: G30.9
- ☐ Mild Cognitive Impairment ICD-10: G31.84
- ☐ Other Alzheimer's Disease ICD-10: G30.8

ORDER FOR KISUNLA (Donanemab-azbt):

- ☐ **Initial Dose:** Infuse 700mg IV every 4 weeks for 3 infusions, then 1400mg IV every 4 weeks x 1 year
- ☐ **Maintenance Dose:** Infuse 1400mg IV every 4 weeks x 1 year

***** The patient will be monitored for 1 hour following the first dose and must have a designated driver present for transportation*

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

PRE-INFUSION REQUIREMENTS:

- ☑ **Baseline MRI is required prior to treatment initiation. MRI findings** must be **reviewed, submitted and approved in writing by the ordering provider before administering the 1st, 2nd, 3rd, 4th, and 7th infusions**, or if the patient develops symptoms suggestive of ARIA (headache, dizziness, nausea, vision changes, or cognitive changes). Infusions must be held, and the provider notified if such symptoms occur.

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Please indicate any tried and failed therapies:_____

Additional REQUIRED Information:

☐ Completion of CMS approved CED registry (Medicare required)
Submission reference #: _____
https://clinicaltrials.gov/

☐ Confirmed presence of amyloid pathology (please include results)
Amyloid PET scan OR +CSF (cerebrospinal fluid)

☐ MRI of the brain (within 1 year, please include results)

☐ Cognitive assessment scores (list all available, please include results)
- ☐ MMSE: Score _____ Date of assessment: _____
- ☐ MoCA: Score _____ Date of assessment: _____
- ☐ CDR: Score _____ Memory box: Score _____ Date of assessment: _____
- ☐ Other: _____ Score: _____ Date of assessment:__ _____

☐ Functional assessment score: _____ (please include results)
Name of Assessment: ☐ FAQ ☐ FAST ☐ Other: _____
Date of assessment: _____

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Revised 04/25