



NEVADA
INFUSION

Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

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

ORDER FOR KISUNLA (Donanemab-azbt):

Initial Dose(please indicate if patient has received initial dose): Infusion 1 - 350 mg IV, Infusion 2 - 700 mg, Infusion 3 - 1050 mg IV, Week 4 and Beyond - 1400 mg IV, 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 and 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. **



NEVADA
INFUSION

Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

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: _____

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. **