Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Kisunla (donanemab-azbt)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS

☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)

☐ Richmond ☐ Prince George

* If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required *

DIAGNOSIS AND ICD-10 CODE

☐ Alzheimer's disease w/ early onset	G30.0	☐ Alzheimer's disease w/ late ons	G30.1
☐ Other Alzheimer's disease	G30.8	☐ Alzheimer's disease, unspecifie	G30.9
☐ Mild Cognitive Impairment, so stated	G31.84		
☑ REQUIRED SECONDARY: Encounter for exam for normal comparison and control in clinical research program			Z00.6
☐ Other: _____	ICD10 _____		

REQUIRED DOCUMENTATION (must include)

- ☐ Current Medication List
- ☐ Clinical/Progress Notes
- ☐ Patient Demographics AND Insurance Information
- ☐ Labs and Tests Supporting Primary Dx
- ☐ Most recent MRI results
- ☐ Confirm patient is NOT on any anticoagulant medication
- ☐ Documentation of positive biomarker for beta amyloid plaques (such as PET scan and/or CSF testing)
- ☐ Genotype testing for ApoE status
- ☐ Documentation of cognitive impairment with the Montreal Cognitive Assessment (MoCA) or other assessment
- ☐ Documentation of functional abilities with the Functional Activities Questionnaire (FAQ) or other assessment
- ☐ If available, the Clinical Dementia Rating (CDR) results
- ☐ Patient currently receiving same therapy at _____ Last dose: _____

MEDICATION ORDERS**

Initial Dosing: ☐ Kisunla 700 mg infuse IV every 4 weeks for 3 infusions, followed by Kisunla 1400 mg every 4 weeks

Maintenance Dosing: ☐ Kisunla 1400 mg infuse IV every 4 weeks

Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____

☐ By checking this box, ordering prescriber agrees to monitor the patient according to the Kisunla package insert with follow-up MRIs prior to the patient's treatment of the **2nd**, **3rd**, **4th** and **7th** doses. MUST **provide results** prior to 2nd, 3rd, 4th and 7th doses to Infusion Solutions.

**For all weight-based therapies, Infusion Solutions will obtain/verify a patient's current weight.

OPTIONAL PREMEDICATIONS and LAB ORDERS

- ☐ Acetaminophen 650 mg PO prior to infusion
- ☐ Diphenhydramine 25 mg PO or IV (per patient preference) prior to infusion
- ☐ Methylprednisolone 40 mg slow IVP prior to infusion
- ☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.