LIFE SPECIALTY SOLUTIONS

KISUNLA
(donanemab-azbt)

PATIENT INFORMATION

PATIENT NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

DATE OF BIRTH: EMAIL:

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. Tried/Failed Therapies 7. MRI within 1 year 8. CSF or PET Scan Showing Amyloid Pathology 9. Cognitive Assessment & Score
10. Medicare Registry #_____ 11. Functional Assessment & Score

PRIMARY DIAGNOSIS

Primary Diagnosis:
☒ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis:
☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild cognitive impairment, so stated

☐ Other:_____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen PO 1000mg, diphenhydramine IV 25mg, methylprednisolone IV 125mg - 30 minutes prior to infusion

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions

☐ Kisunla 350mg IV at week 0, 700mg IV at week 4, 1050mg IV at week 8, followed by 1400mg IV every 4 weeks thereafter

☐ Other: _____

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: PHONE:

OFFICE CONTACT: FAX:

ADDRESS: EMAIL:

CITY, STATE, ZIP: NPI AND LICENSE:

✖ _____ _____

PROVIDER SIGNATURE DATE