

Kisunla™ (donanemab-azbt) MRI Confirmation Documentation

Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches cm

Weight:

lbs kg

Clinical Information

Primary Diagnosis Description:

ICD-10 Code:

Details needed for therapy:

- Brain MRI must be provided prior to the 2nd, 3rd, 4th, and 7th infusions.

MRI Confirmation Details

MRI completed on (date): _____

MRI completed prior to (check one): 2nd infusion

3rd infusion

4th infusion

7th infusion

MRI reviewed on (date): _____

Plan:

May continue dosing as ordered.

Suspend dosing.

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

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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