Kisunla® (donanemab-azbt) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Patient Registry Name:	**Patient Registry #:**	
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Supporting documentation required for therapy:

- Baseline brain MRI from within the past year. Subsequent brain MRI reports and written approval by the ordering prescriber must be obtained prior to the 2nd, 3rd, 4th, and 7th infusions.

Kisunla® (donanemab-azbt) Prescription

Kisunla® (donanemab-azbt) in 0.9% sodium chloride refill as directed x 1 year

☐ **Standard dosing**

Infusion 1:	Infuse 350mg IV x1
Infusion 2:	Infuse 700mg IV x 1, 4 weeks after Infusion 1
Infusion 3:	Infuse 1050 mg IV x1, 4 weeks after Infusion 2
Infusion 4 and beyond	Infuse 1400 mg IV every 4 weeks, beginning 4 weeks after Infusion 3

☐ **Other:** _____

Medication will be infused over approximately 30 minutes.
Using a 50ml 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10 to 20 mL after each infusion.
Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

Ancillary Orders

Anaphylaxis Kit

Anaphylaxis kit to be provided with each dose?:

☐ Yes ☐ No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500mL (>30kg) or 250mL (≤30kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 3 to 5 mL pre-/post-use
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

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