

# Kisunla™ (donanemab-azbt) MRI Confirmation Documentation

Patient Name:		Date of Birth:	
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

## Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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### Details needed for therapy:

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

## MRI Confirmation Details

MRI completed on (date): \_\_\_\_\_

- MRI completed prior to (check one):
- 2<sup>nd</sup> infusion
- 3<sup>rd</sup> infusion
- 4<sup>th</sup> infusion
- 7<sup>th</sup> 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:

### Fax completed form, insurance information, and clinical documentation to:

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