Agile Infusion Services LLC
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KISUNLA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ Diagnosis

☐ G31.84 Mild cognitive impairment, so stated
☐ G30.0 Alzheimer's with early onset (at <65y/o)
☐ G30.1 Alzheimer's with late onset (at ≥65y/o)
☐ G30.8 Other Alzheimer's disease

■ Details Needed for Approval

- Medical records documenting the level of cognitive impairment are required. (Usually it must be mild for approval.)
- Supporting documentation of patient's neurological history, including relevant tests and laboratory results, all available dementia/impairment scores (such as CDR, MMSE, SLUMS and MoCA), differential diagnoses (ie. DLB, FTD, etc.), and patient counseling related to amyloid-related imaging abnormalities.
- Has the patient had a TIA, stroke or seizure within the past twelve (12) months? _____
- Documentation of the presence of amyloid beta pathology via PET or CSF. If CSF, document why was PET not obtained.
- Brain MRI from within the past year. **A new brain MRI must be provided prior to the 2nd, 3rd, 4th and 7th infusions.**
- There is a risk of Amyloid Related Imaging Abnormalities (ARIA). Testing for and clinical evaluation regarding ARIA before and during therapy, and the decision on whether to suspend therapy, remains the sole responsibility of the ordering provider**. The MRI reports and ordering provider written evaluations must be provided before the start of each round of therapy.**
- APOE genotyping results on lab letterhead. (If testing not performed, documentation of patient education re increased ARIA risk must be provided.)
- Will the patient be concurrently treated with other Alzheimer's therapy such as Leqembi? _____
- Does the patient have a bleeding disorder which is not currently under control? _____
- If patient will concurrently be on an anticoagulant, please include documentation of counseling that use of Kisunla with such therapy increases risk of cerebral macrohemorrhage and that patient and/or guardian has shared in the decision-making to undergo Kisunla therapy while on anticoagulant therapy.
- For Medicare patients, you must provide the patient's CMS National Patient Registry trial number: _____

■ Pre-Medication Order (optional) *IV pre-medications to be administered 15 minutes prior to the start of the infusion treatment.*

☐ Diphenhydramine _____mg ☐ Dexamethasone _____mg ☐ Methylprednisolone _____mg

■ Kisunla (donanemab-azbt) Medication Order *Note: Only a single course can be selected per order form.*

☐ 700mg IV initial dose
☐ 700mg IV 2nd dose 4 weeks after prior dose
☐ 700mg IV 3rd dose 4 weeks after prior dose
☐ 1,400mg IV each, doses #4 - #6, every 4 weeks
☐ 1,400mg IV per each additional dose, starting with treatment #7, every 4 weeks, for _____ months

Medication shall be added to 0.9% NaCl infusion as directed and infused over about 30 minutes. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion. Observe for 30 minutes after completion.

■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.