

Donanemab-azbt (Kisunla)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)
• MRI within 1 year • Amyloid Pathology Confirmation • Cognitive Assessment & Score • Functional Assessment & Score

DIAGNOSIS ICD-10 CODE (Provider must specify)

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

REQUIRED DOCUMENTATION

Referring providers must register patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration prior: <https://qualitynet.cms.gov/alzheimers-ced-registry/submission>

Attach proof of CMS Registry Confirmation or provide below:

Issue Number: ALZH- _____
Date of Submission: _____

☐ I, the prescribing provider, am responsible for ordering and reviewing all MRIs of the brain for this patient. By checking this box, I acknowledge that I have obtained and reviewed a baseline (within 1 year) MRI and communicated the results to the patient or his/her legal guardian will obtain and review an MRI prior to the 2nd, 3rd, 4th, and 7th infusions.

ARIA MRI Classification & Monitoring: MRI is required prior to the 2nd, 3rd, 4th, and 7th infusions. ARIA-H (microhemorrhage) is graded mild (≤ 4 new microhemorrhages), moderate (5–9), or severe (≥ 10 , or any macrohemorrhage $> 1\text{cm}$); ARIA-H (superficial siderosis) is graded mild (1 focal area), moderate (2 areas), or severe (> 2 areas). ARIA-E (edema/effusion) is graded mild (one site $< 5\text{cm}$), moderate (one site 5–10cm, more than one site, or gyral swelling/sulcal effacement), or severe (one or more sites $> 10\text{cm}$). For moderate or severe findings in any category, suspend dosing until MRI demonstrates radiographic resolution/stabilization and symptoms, if present, resolve; mild findings may continue with ongoing monitoring. Grading reflects new findings only, compared to baseline MRI. If symptoms suggestive of ARIA occur (headache, confusion, visual changes, dizziness, nausea, seizure), obtain urgent MRI regardless of the scheduled interval — ARIA-E can mimic acute ischemic stroke, so ARIA must be ruled out before administering thrombolytic therapy.

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

PRIMARY MEDICATION ORDER

☒ Referring provider must obtain and review new MRI and provide clearance prior to the 2nd, 3rd, 4th, and 7th infusions

Donanemab-azbt (Kisunla) 350mg IV at Week 0, 700mg IV at Week 4, 1050mg IV at Week 8, followed by 1400mg IV every 4 weeks thereafter
• Infuse over 30 minutes
• Flush with 0.9% Sodium Chloride at the completion of infusion
• Monitor patient for 30 minutes post infusion
• Refill for 12 months unless otherwise noted: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Kisunla

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

Ordering Provider (Print)

Provider Signature

Provider NPI

Date

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

☐ Arbor Infusion Fishers (317) 981-1772