

# KISUNLA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: \_\_\_\_\_

## Patient Information

Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	Phone:	Email:
Height (in):	Weight (lb):	Referral Status: <input type="checkbox"/> New <input type="checkbox"/> Updated <input type="checkbox"/> Renewal

## Infusion/ Injection Information

Primary ICD-10 Code:	Primary ICD-10 Description:
Other ICD-10 Codes:	Other ICD-10 Descriptions:

### Kisunla (Donanemab-azbt) Dosing Info:

- Initial Dose: 700mg IV at week 0, 4, 8
- Maintenance Dose: 1400mg IV every 4 weeks

### Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies
- CMS Registry Confirmation Email (Medicare Patients)
- MRI (Baseline and prior to 2nd, 3rd, 4th, 7th infusion)
- Positive CSF or Amyloid PET Scan
- Cognitive Assesment Score \_\_\_\_\_
- Patient has been provided ARIA Risk counseling

### Premedications:

- Acetaminophen \_\_\_\_\_ mg  
 PO  IV
- Cetirizine \_\_\_\_\_ mg  PO
- Diphenhydramine \_\_\_\_\_ mg  
 PO  IV
- Hydrocortisone \_\_\_\_\_ mg  IV
- Loratadine \_\_\_\_\_ mg  PO
- Methylprednisolone \_\_\_\_\_ mg  IV
- Other: \_\_\_\_\_ mg  
 PO  IV

## Ordering Provider Information

Practice Name:	Practice Phone:	Practice Fax:
Practice Address:	Referral Coordinator Name:	
Referral Coordinator Email:	Referral Coordinator Phone:	
Ordering Provider:	Provider NPI:	Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name

Provider Signature

Date