INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Kisunla *donanemab-azbt*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Alzheimer's Disease, ICD 10: G30.9
☐ Alzheimer's Disease with Early Onset, ICD 10: G30.0
☐ Alzheimer's Disease with Late Onset, ICD 10: G30.1
☐ Other Alzheimer's Disease, ICD 10: G30.8

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Baseline MRI within 1 year, with repeat MRIs needed prior to the 2nd, 3rd, 4th, and 7th infusion
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Kisunla	☐ Step dosing: Infusion 1: 350 mg; Infusion 2 (4 weeks later): 700 mg; Infusion 3 (4 weeks later): 1,050 mg; Infusion 4 and every 4 weeks: 1,400 mg ☐ Maintenance: 1,400 mg	IV	☐ Every 4 weeks (after initial x3 step-dosing infusions) ☐ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____