

Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629



Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Kisunla® (donanemab) Order Form
Epic Referral: REF115256

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** Z00.6, _____

Induction:

IV donanemab 350 mg at week 0, then 700 mg at week 4, then 1050 mg at week 8, followed by maintenance dosing at week 12

Maintenance:

IV donanemab 1400 mg infused every 4 weeks

Pre-meds/PRN Orders: (given at each infusion)

- Tylenol 1000 mg po or Tylenol 650 mg po
 Benadryl _____ mg po or Benadryl _____ mg IV
 Zofran 4 mg PO prn nausea or Zofran 4 mg IV prn nausea
 Other: _____

Duration: 6 months 1 year Other duration: _____

For Medicare/Medicaid & Medicare Advantage patients:

To receive coverage for the medication, patients must be enrolled in the CMS National Patient registry prior to starting therapy and every 6 months through the first 24 months of treatment.

CED Study Identifier: NCT06058234 Other: _____

Date of Last Enrollment: _____ **Enrollment Number:** _____

- Faxed clinical documentation of recent (baseline) MRI and confirmation of amyloid beta pathology
 Faxed clinical documentation of ApoE ε4 status for ARIA risk assessment
 REQUIRED **Prior to 2nd, 3rd, 4th, and 7th infusions an MRI report and provider written approval of ARIA risk level must be faxed to Kettering infusion (937-401-6629).

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____