Donanemab-azbt (Kisunla)

IVX HEALTH

Provider Order Form *rev. 8/21/26*

Patient Status: ☐ New to IVX, Last Infusion Date: ☐ Established IVX Kisunla Patient **(If selected, only *fields are required)**

PATIENT INFORMATION

Date*: **Patient Name*:** **DOB*:**

ICD-10 code (required): ICD-10 description: **Infusion Number***:

☐ NKDA Allergies: Weight (lbs/kg): Height:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider*: **Provider NPI*:**

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REFERRING PROVIDER (ALL BOXES BELOW MUST BE CHECKED)

☐ I have reviewed the prescribing info. and medication guide for Kisunla

☐ I acknowledge IVX clinicians will provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation **NOTE:** IVX Adverse Reaction Management Protocol available at www.ivxhealth.com/forms (version 5.1.2023)

☐ Provide supporting clinical documentation including:

- Positive amyloid pathology testing (amyloid PET scan, cerebrospinal fluid [CSF] amyloid biomarker, or blood-based amyloid biomarker)
- Clinical documentation including a neurologic evaluation supporting accurate diagnosis and eligibility of mild cognitive impairment or mild dementia. Ex: Mini Mental Status Exam (MMSE)
- ARIA MRI Classification Criteria: If ≥ 5 new incident microhemorrhages or > 2 new focal areas of superficial siderosis (indicating moderate radiographic severity for ARIA-H) are observed, treatment will not be initiated until MRI demonstrates radiographic stabilization and symptoms, if present, resolve. If any of the following are noted: FLAIR hyperintensity >5 cm in a single greatest dimension, more than 1 site of involvement, gyral swelling or sulcal effacement (indicating moderate radiographic severity for ARIA-E), treatment must be suspended until MRI demonstrates radiographic resolution and symptoms, if present, resolve

☐ **I, the prescribing provider, am responsible for ordering reviewing, and acting upon all MRI findings required by the Kisunla prescribing information. I understand IVX does not interpret MRI studies and relies upon my clinical determination that the patient remains appropriate for treatment. By checking this box/signing this order, I certify that all manufacturer-required MRI evaluations will be completed and reviewed before applicable infusions are administered; I will notify IVX if the MRI does not occur. I acknowledge IVX reserves the right to hold treatment if notified that required MRI monitoring has not occurred.**

APPEALS PROCESS

Upon denial, IVX will appeal with a Letter of Medical Necessity unless you opt out:

☐ Opt out (I will manage any denial)

PRE-MEDICATION ORDERS (OPTIONAL NOT REQUIRED BY MANUFACTURER)

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

CMS REGISTRY: REQUIRED DOCUMENTATION

Referring providers must register patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration prior. **Registration/new ALZH number required every 6 months*: https://qualitynet.cms.gov/alzheimers-ced-registry/submission

Issue Number: ALZH-_____ Date of Submission: _____

THERAPY ADMINISTRATION

Kisunla (donanemab-azbt) will be prepared and infused to achieve a final concentration of 4 mg/mL to 10 mg/mL per manufacturer guidelines. ***IVX will pursue an authorization per the dosing schedule outlined in the manufacturer's PI***

- **Dose**: ☐ **New to therapy**: #1 350 mg | #2 700 mg | #3 1050 mg #4–6 1400 mg; IV every 4 weeks (duration: first 6 infusions)
  ☐ **Maintenance:** 1,400 mg IV every 4 weeks for 6 infusions
  ☐ **Other:** _____

(If other, indicate # of refills, not to exceed 6m. If not indicated, refills expire 6m from date signed)

Refills: _____

- **Rate**: Infuse over 30 minutes
- **Post Infusion:** Flush with 0.9% Sodium Chloride at the completion of infusion. Monitor patient for 30 minutes post infusion

Provider Name (Print) **Provider Signature** **Date**

IVX HEALTH FAX NUMBERS

☐ ARKANSAS: 501-451-5644
☐ AUSTIN: 512-772-2824
☐ BAY AREA: 844-889-0275
☐ CENTRAL JERSEY: 640-252-6633
☐ CHARLOTTE: 336-663-0143
☐ CHICAGO: 312-253-7244
☐ CINCINNATI: 844-946-0868
☐ COLLEGE STN: 979-205-4686
☐ COLUMBUS: 844-627-2675
☐ CONNECTICUT: 860-955-1532
☐ COOKEVILLE: 931-479-1395
☐ DALLAS: 469-947-6114
☐ DAYTONA: 386-259-6096
☐ DELAWARE: 302-596-8553
☐ EAST TN/TRI-CITIES: 615-425-7427
☐ FT. LAUDERDALE: 754-946-2052
☐ FT. WAYNE: 260-369-2310
☐ HARRISBURG: 844-859-4235
☐ HOUSTON: 832-631-9595
☐ INDIANAPOLIS: 844-983-2028
☐ JACKSONVILLE: 904-212-2338
☐ KANSAS CITY: 844-900-1292
☐ LAKELAND: 863-316-3910
☐ LONG ISLAND: 363-201-6975
☐ MELBOURNE: 321-800-9515
☐ MIAMI: 786-744-5687
☐ MIDDLE/WEST TN: 888-615-1445
☐ NC FL: 352-756-4191
☐ NORTH JERSEY: 551-227-2823
☐ NYC: 332-334-0809
☐ ORLANDO: 844-946-0867
☐ PALM BEACH: 561-768-9044
☐ PHILADELPHIA: 844-820-9641
☐ PIEDMONT TRIAD: 336-790-2200
☐ RALEIGH: 919-287-2551
☐ SAN ANTONIO: 726-238-9950
☐ SARASOTA: 941-870-6550
☐ SOUTH JERSEY: 856-519-5309
☐ SOUTHWEST FL: 813-283-9144
☐ TAMPA: 844-946-0849
☐ WACO: 254-343-7650