

Donanemab-azbt (Kisunla) 1st Infusion Only



Provider Order Form rev. 2/12/26

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

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

Patient Status: New to Therapy Next Due Date: _____

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

- I have reviewed the prescribing information and medication guide for Kisunla (donanemab-azbt)
- 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 beta pathology testing (Amyloid Beta PET Scan or biomarker testing)
 - 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 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. IVX Health is safe to proceed with the patient's donanemab-azbt (Kisunla) infusion**

PRE-MEDICATION ORDERS (OPTIONAL AND 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: _____

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: _____

THERAPY ADMINISTRATION

Kisunla (donanemab-azbt) will be prepared and infused according to the [prescribing information](#) provided by the manufacturer. **NOTE: IVX Health will pursue an authorization per the dosing schedule outlined in the manufacturer's PI. However, a new order and subsequent MRIs of the brain must be completed and reviewed prior to the 2nd, 3rd, 4th, and 7th Kisunla (donanemab-azbt) infusions**

- **Preparation:** Prepare Kisunla (donanemab-azbt) to achieve a final concentration of 4 mg/mL to 10 mg/mL per manufacturer guidelines
- **Dose:** Kisunla (donanemab-azbt) 350 mg IV
- **Rate:** Infuse over 30 minutes
- **Frequency:** Every four weeks for 1 dose
- **Post Infusion:** Flush with 0.9% Sodium Chloride at the completion of infusion. Monitor patient for 30 minutes post infusion

APPEALS PROCESS

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

Provider Name (Print)

Provider Signature

Date

IVX HEALTH FAX NUMBERS

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