

# Donanemab-azbt (Kisunla) 7<sup>th</sup> Infusion and Beyond



This order form is valid for infusion after patient has completed all MRI requirements

Provider Order Form rev. 2/17/26

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

## PATIENT INFORMATION

<b>Date*:</b>	<b>Patient Name*:</b>	<b>DOB*:</b>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight (lbs/kg):	Height:

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
<b>Ordering Provider*:</b>	<b>Provider NPI*:</b>		
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 Health clinicians will provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation **NOTE:** IVX Adverse Reaction Management Protocol available for review at [www.ivxhealth.com/forms](http://www.ivxhealth.com/forms) (version 05.01.2023)
- 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 all MRIs as required by the manufacturer's prescribing information and communicated the results to the patient or his/her legal guardian. IVX Health is safe to proceed with the patient's Kisunla (donanemab-azbt) infusions.**

## 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 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.

- **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) 1,400mg IV
- **Rate:** Infuse over 30 minutes
- **Frequency:** Every 4 weeks beginning 4 weeks from the previous dose
- **Post Infusion:** Flush with 0.9% Sodium Chloride at the completion of infusion. Monitor patient for 30 minutes post infusion

- Refills (not to exceed 6 months):  Zero /  for 6 months /  \_\_\_\_\_  
(if not indicated order will expire 6 months from date signed)

## Provider Name (Print)

## Provider Signature

## Date

### IVX HEALTH FAX NUMBERS

- |  |   |   |   |   |
|--|---|---|---|---|
| <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"/> 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"/> 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"/> ARKANSAS: 501-451-5644    | <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"/> AUSTIN: 512-772-2824      | <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"/> BAY AREA: 844-889-0275    | <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"/> CHARLOTTE: 336-663-0143   | <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"/> CHICAGO: 312-253-7244     | <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         |