Kisunla™

Provider Order Form Rev. 07/2025

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

Mild Alzheimer's Disease Dementia

☐ Alzheimer's disease with early onset, G30.0
☐ Alzheimer's disease with late onset, G30.1
☐ Other Alzheimer's disease, G30.8
☐ Alzheimer's disease, unspecified, G30.9

Mild Cognitive Impairment due to Alzheimer's Disease

☐ Mild cognitive impairment, G31.84

Secondary diagnosis ☐ For Medicare: must include ICD10 Z00.6

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Kisunla™ (donanemab-azbt)	**INITIAL:** 350mg, 700mg, 1050mg **MAINTENANCE:** 1400mg	☐ **INITIAL:** Infuse IV over 30 minutes every 4 weeks x 3 doses ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 4 weeks x 1 year *Observe patient for 30 minutes after completion of infusion.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ CBC w/diff and Platelets q _____ ☐ CMP q _____
☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has been diagnosed with Alzheimer's disease. Date of clinical diagnosis (required): _____

☐ The patient has documented mild cognitive impairment or mild dementia stage of Alzheimer's disease.

Please indicate method(s) for assessment and attach copy:

☐ Montreal Cognitive Assessment (MoCA)
☐ Mini-Mental State Exam (MMSE)
☐ Alzheimer's Disease Assessment Scale (ADAS-Cog14)
☐ St. Louis University Mental Status Exam (SLUMS)
☐ Other: _____

☐ The patient's functional abilities have been assessed.

Please indicate method(s) for assessment and attach copy:

☐ Functional Activities Questionnaire (FAQ)
☐ Functional Assessment Staging Tool (FAST)
☐ Alzheimer's Disease Cooperative Study – Activities of Daily Living Inventory Scale (ADCS-ADL-MCI)
☐ Other: _____

☐ A Clinical Dementia Rating-Global Score (CDR-GS) was completed. ***Please attach copy of assessment form.***

☐ The patient has a positive biomarker for beta amyloid plaques.

☐ Amyloid positron emission tomography (PET) scan
☐ Cerebrospinal fluid (CSF) testing
☐ Other: _____

☐ The patient has a recent (within one year) brain MRI scan. Date of MRI: _____

Referring provider is responsible for scheduling and obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions.

☐ A genotype testing for ApoE ε4 status was completed. ***Please attach copy of test result.***

☐ The patient will not be receiving anticoagulation therapy or antiplatelets while on Kisunla™.
If currently on anticoagulants or antiplatelets, please specify drug and dose: _____

LAB AND TEST RESULTS (required)

☐ Amyloid PET scan ☐ CSF biomarker results ☐ MRI brain scan ☐ ApoE ε4 status results ☐ Other: _____

For Medicare patients: ☐ Referring practice to complete CED Study Registry submission; Initial Registry #: ALZH-_____
☐ Healix Infusion Care to submit and manage CED Study Registry submission on behalf of referring provider/practice