

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*

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
Secondary diagnosis For Medicare: must include ICD10 Z00.6

Mild Cognitive Impairment due to Alzheimer's Disease
 Mild cognitive impairment, G31.84

**ICD 10 Code Required*

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Kisunla™ (donanemab-azbt)	INITIAL: 350mg, 700mg, 1050mg MAINTENANCE: 1400mg	<input type="checkbox"/> INITIAL: Infuse IV over 30 minutes every 4 weeks x 3 doses <input type="checkbox"/> 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)
 - Other: _____
 - Alzheimer's Disease Assessment Scale (ADAS-Cog14)
 - St. Louis University Mental Status Exam (SLUMS)
- 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)
 - Other: _____
 - Alzheimer's Disease Cooperative Study – Activities of Daily Living Inventory Scale (ADCS-ADL-MCI)
- 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
 - Blood 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