Kisunla (donanemab-azbt) Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____
DOB: _____
Phone Number: _____
Allergies: _____
Height (in): _____ Weight (kg): _____

Ordering Provider:_____
NPI:_____
Primary Care Provider:_____
Insurance Information: _____

Referral Status

☐ New Referral
☐ Dose or Frequency Change
☐ Order Renewal

Has the patient been treated for this condition previously?
☐ No ☐ Yes, medication(s): _____
_____

Diagnosis & Required Information

Diagnosis and ICD-10 Code(s):
☐ _____
☐ _____

Required Information:
☐ Patient face sheet
☐ Clinical/Progress note
☐ Labs/Tests supporting diagnosis

Medication Order

Drug: Kisunla (donanemab-azbt)

Dose:
☐ Induction: 700mg IV every 4 weeks x 3 doses
☐ Maintenance: 1400mg IV every 4 weeks

Pre-medications:
☐ Acetaminophen PO: _____mg
☐ Cetirizine (Zyrtec) PO: _____mg
☐ Other: _____
☐ Famotidine IV: _____mg
☐ Methylprednisolone IV: _____mg

Labs:
☐ CBC w/diff, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ CMP routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ Other: _____ ☐ Days ☐ Weeks ☐ Months

***OSI Hypersensitivity protocol: Solumedrol, Benadryl, or Famotidine could be used in the event of a hypersensitivity reaction. Referring office will be notified if this occurs*

Ordering Physician's Signature: _____ Date: _____

Provider Name: _____ Office Phone: _____ Office Fax: _____

**This order will expire 365 days from order date*