

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  lbs  kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

**<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION**

**ICD 10 Code (PROVIDE COMPLETE CODE)**

**PRIMARY (SELECT ONE)**

- G30.0 Alzheimer's disease with early onset
- G30.1 Alzheimer's disease with late onset
- G30.8 Other Alzheimer's disease

**SECONDARY (SELECT ONE)**

- F02.80 Dementia in other diseases classified elsewhere
- G31.84 Mild Cognitive Impairment of uncertain or unknown etiology
- Other: \_\_\_\_\_

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, imaging, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

**LAB RESULTS:** Include baseline brain MRI prior to initiating treatment

**PRESCRIPTION**

**Pre-Medications**

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Dexamethasone: \_\_\_\_\_ mg IV
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IV
- Other: \_\_\_\_\_
- Acetaminophen: \_\_\_\_\_ mg PO
- Famotidine: \_\_\_\_\_ mg IV
- Loratadine 10 mg PO
- Methylprednisolone: \_\_\_\_\_ mg IV
- Ondansetron 4 mg IV

**Lab Orders**

- CBC w/diff: every \_\_\_\_\_  weeks  month
- CMP: every \_\_\_\_\_  weeks  month
- Other: \_\_\_\_\_  weeks  month

**Kisunla (donanemab – azbt)**

Administer Kisunla as IV infusion every 4 weeks as follows:

**Loading Dose (Select all that apply)**

- Infusion 1: infuse 350 mg x 1 dose
- Infusion 2: infuse 700 mg x 1 dose
- Infusion 3: infuse 1,050 mg x 1 dose

**Maintenance Dose (Select One)**

- Infusion 4 and beyond: infuse 1400mg every 4 weeks x 1 year

**\*\* If patient has received loading dose at a different infusion site, please provide clinical notes supporting documentation. \*\***

**\*\* Please fax MRI results prior to each infusion of the 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and any ongoing MRIs along with office visit notes for the duration of treatment. \*\***

Is the patient on any other disease modifying therapy?  Yes  No

If yes, please note therapy and last dose: \_\_\_\_\_

**Adverse Events:** In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**PRESCRIBING INFORMATION**

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_