Donanemab-azbt (Kisunla) *3rd Infusion Only*

IVX HEALTH

Provider Order Form *rev. 10/28/25*

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

PATIENT INFORMATION

Date*: **Patient Name*:** **DOB*:**

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider*: **Provider NPI*:**

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 (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 a subsequent MRI (completed after infusion 2, prior to infusion 3) 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) infusion.**

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 FOR NEW REFERRALS ONLY

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. ***NOTE: IVX Health will pursue an authorization per the dosing schedule outlined in the manufacturer's PI. However, a new order and subsequent MRIs of the brain must be completed and reviewed prior to the 4th-6th and 7th and beyond***

- **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) 1,050mg IV
- **Rate**: Infuse over 30 minutes
- **Frequency**: Every 4 weeks for 1 dose
- **Post Infusion:** Flush with 0.9% Sodium Chloride at the completion of infusion. Monitor patient for 30 minutes post infusion

Provider Name (Print) **Provider Signature** **Date**

IVX HEALTH FAX NUMBERS

	☐ CHICAGO: 312-253-7244	☐ EAST TN/TRI-CITIES: 615-425-7427	☐ MELBOURNE: 321-800-9515	☐ PIEDMONT TRIAD: 336-790-2200
	☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ MIAMI: 786-744-5687	☐ RALEIGH: 919-287-2551
	☐ COLLEGE STN: 979-205-4686	☐ HARRISBURG: 844-859-4235	☐ MIDDLE/WEST TN: 888-615-1445	☐ SAN ANTONIO: 726-238-9950
	☐ COLUMBUS: 844-627-2675	☐ HOUSTON: 832-631-9595	☐ NORTH CENTRAL FL: 352-756-4191	☐ SARASOTA: 941-870-6550
☐ ARKANSAS: 501-451-5644	☐ CONNECTICUT: 860-955-1532	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH JERSEY: 551-227-2823	☐ SOUTH JERSEY: 856-519-5309
☐ AUSTIN: 512-772-2824	☐ DALLAS: 469-947-6114	☐ JACKSONVILLE: 904-212-2338	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ LAKELAND: 863-316-3910	☐ PHILADELPHIA: 844-820-9641	☐ WACO: 254-343-7650