

Donanemab-azbt (Kisunla) 7th Infusion and Beyond



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:	
<input type="checkbox"/> 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 6, prior to infusion 7) 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

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 is required 1 year from initiation of therapy.**

- 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) 1,400mg IV
- Rate:** Infuse over 30 minutes
- Frequency:** Every 4 weeks for 6 total infusions beginning 4 weeks from the previous 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

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