Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 01/2025

OFFICE: Complete the entire form and submit pages 1-4 to Lilly Support Services™ via fax at 1-844-731-2697. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Section 5: Prescriber Information

Name (First, Last) _____ **NPI #** _____

PTAN # _____ **Tax ID #** _____ **Phone** 215-957-9250 **Fax** 215-957-9254

Address 1151 Old York Road, Suite 200 **City** Abington **State** PA **Zip** 19001

Office Contact Name _____ **Office Contact Phone** _____

Office Contact Email _____

Collaborating Physician _____ **NPI #** _____ **Group Tax ID** 232130597

Section 6: Service Selection

Benefits Investigation

Who is conducting the Benefits Investigation? Please select the appropriate option from the following:

☐ **HCP or Infusion Center Conducted Benefits Investigation** - The Prescriber's office, referred Infusion Center, or another party (e.g., Specialty Pharmacy) will research the Patient's insurance to help identify the lowest out-of-pocket cost available for Kisunla™.
(Proceed to Care Coordination and Infusion Center Locator Support service requests, if desired)

OR

☐ **Lilly Conducted Benefits Investigation** - Lilly Support Services™ will research the Patient's insurance to help identify the lowest out-of pocket cost available for Kisunla™, which may include Patient eligibility for a Savings Card. A Lilly Support Services™ representative will help troubleshoot access issues on the Patient's behalf and determine eligibility for a program Savings Card, if applicable.
(Please make additional Benefits Investigation selections, if desired)

As part of the Lilly Conducted Benefits Investigation, Lilly Support Services™ can also research estimated costs associated with the treatment of Kisunla™. Please select any additional costs that you would like Lilly Support Services™ to investigate:

- ☐ Infusion administration estimate
- ☐ MRI estimate (CPT# 70551: MRI, brain, including brain stem, without dye)

If coverage attempts (e.g., Prior Authorization, Pre-Certification, etc.) are required for Kisunla™, the party responsible for completing the coverage attempt(s) will be:

- ☐ Prescribing HCP
- ☐ Referred Infusion Center

☐ **Care Coordination** – This service on behalf of your Patients helps facilitate confirmation of requirements across their Kisunla™ treatment team, such as MRIs or other medical documentation. Reminders will be provided to HCPs when additional documentation or tests are needed for Patients on Kisunla™. Lilly Support Services™ helps your Patients navigate the logistics associated with treatment to support a smoother experience while on Kisunla™. Lilly Support Services™ for Kisunla™ recommends that the Lilly Conducted Benefits Investigation service is also selected so that additional information can be gathered that will enable Care Coordination follow ups at the appropriate time. In the absence of a Benefits Investigation, Lilly Support Services™ for Kisunla™ will conduct Care Coordination following the Medicare Patient process unless otherwise marked on the enrollment.

Infusion Center Locator Support (must select one choice below) – Lilly Support Services™ can help your Patient locate a convenient infusion site to receive their Kisunla™ treatment. Additionally, if Lilly Conducted Benefits Investigation is selected, Lilly Support Services™ will also attempt to gather the network status of identified infusion sites. If the Prescriber is not infusing in the office and Sections 7, 8, 9, and 10 are completed, Lilly Support Services™ will send the prescription and infusion order to the selected infusion site.

☐ Prescriber is requesting support in locating an Infusion Center

OR

☐ Prescriber will infuse in office (information listed in Section 5 above)
Please provide the Practice Name _____
and the Organizational NPI # _____ for the In-Office Infusion Center
(IF SELECTED, SKIP INFUSION CENTER LOCATION AND SECTIONS 8 AND 9)

OR

☐ Prescriber is referring to the following site (**IF SELECTED, MUST FILL OUT INFUSION CENTER LOCATION SECTION BELOW**):

Infusion Center Location – Must be completed if Prescriber selected a Referral Infusion Site

Infusion Center Type:

☐ **Non-Prescribing MD's Office** ☐ **Hospital Outpatient** ☐ **Stand-Alone Infusion Center** ☐ **Other** _____

Office/Hospital/Other Name _____

Street Address _____ **City** _____ **State** ____ **Zip** _____

Office Contact _____ **Phone** _____ **Fax** _____

NPI # _____ **PTAN #** _____

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PRESCRIPTION AND INFUSION ORDER FORM

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Section 7: Patient Information and Diagnosis

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Allergies _____

Current Medications _____

Other Medical Conditions or Additional Comments: _____

Medical History Related to IV Insertion (e.g. lymph nodes or mastectomy): _____

Diagnosis

- ☐ **G30.0 Alzheimer's disease with early onset**
- ☐ **G30.1 Alzheimer's disease with late onset**
- ☐ **G30.8 Other Alzheimer's disease**
- ☐ **G30.9 Alzheimer's disease, unspecified**
- ☐ **G31.84 Mild cognitive impairment, so stated**

Note: If Prescriber is infusing In-Office, Sections 8 and 9 are not required.

Section 8: Prescription

The Prescriber is requesting the following regarding the prescription and infusion order:

☐ Lilly Support Services™ will triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE COMPLETE SECTIONS 8 AND 9)**

OR

☐ Lilly Support Services™ will **NOT** triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE PROCEED to Section 10)**

Kisunla™ Prescription — Fill out corresponding prescription below and sign at the bottom of the page

Kisunla™ Dosing	Quantity	Days Supply	Refills
☐ Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3	2 vials	28	2
☐ Dose Post Infusion 3: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 vials	28	_____

You must select at least one Dosing option. You may select both.

Section 9: Infusion Order Information Protocol

Administration Protocol:

IV Infusion (every 4 weeks)	Kisunla™ Dosage (administered over approximately 30 min)
Infusions 1, 2, and 3	700 mg
Infusions 4+	1400 mg

- Observe the Patient post-infusion for a minimum of 30 minutes to evaluate for infusion reactions and hypersensitivity reactions
- At first observation of any signs or symptoms consistent with a hypersensitivity or infusion-type reaction, stop infusion and treat per orders/protocol, as clinically indicated
- Schedule treatments every 4 weeks. Order valid for one year unless otherwise indicated:
  - ☐ Order expires on: _____
  - ☐ Order expires after _____ treatments

Post-Infusion:

- Send treatment notes to Prescriber via fax to: _____ or via email to: _____

Section 10: Prescriber Signature

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to Eli Lilly and Company, Lilly USA, LLC, their affiliates, agents, representatives, business partners, and service providers (together "Lilly") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to Lilly so that Lilly may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support Lilly provides. I understand that by signing this form, I am requesting support from Eli Lilly and Company for a Patient receiving Kisunla™ pursuant to an FDA approved indication and attest that the Patient is eligible to undergo MRI per the Kisunla label.

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

_____ _____

Prescriber Signature **Date Signed (MM/DD/YYYY)**

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly