

# Kisunla™ (donanemab-azbt) PRESCRIBER ORDER FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Height: \_\_\_\_\_  inches  cm Weight: \_\_\_\_\_  lbs  kg

## Clinical Information

Primary Diagnosis Description: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

### Supporting documentation required for therapy:

- Baseline brain MRI from within the past year. Subsequent brain MRI reports and written approval by the ordering prescriber must be obtained prior to the 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, and 7<sup>th</sup> infusions.

## Kisunla™ (donanemab-azbt) Prescription

### Kisunla™ (donanemab-azbt) in 0.9% sodium chloride refill as directed x 1 year

Initial Dose:  Infuse 700mg IV every 4 weeks for 3 infusions.

Maintenance Dose:  Infuse 1400 mg IV every 4 weeks.

Medication will be infused over approximately 30 minutes with a 0.2 micron filter.

Using a 50ml 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10 to 20 mL after each infusion.

Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

## Ancillary Orders

### Anaphylaxis Kit

If this is a 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?

Yes  No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500mL (>30kg) or 250mL (≤30kg) IV at KVO rate PRN anaphylaxis.

### Medication Orders

Other: \_\_\_\_\_

### IV Flush Orders

Peripheral: 0.9% Sodium Chloride 2-3 mL pre-/post-use

Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

### Lab Orders

No labs ordered at this time.

Other: \_\_\_\_\_

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.

Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ NPI: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### Fax completed form, insurance information, and clinical documentation to:

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