INTRAMED Plus
infusion services

KISUNLA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Alzheimer's disease with early onset — ICD-10 Code: G30.0
_____ Alzheimer's disease with late onset — ICD-10 Code: G30.1
_____ Other Alzheimer's disease — ICD-10 Code: G30.8
_____ Alzheimer's disease, unspecified — ICD-10 Code: G30.9
_____ Mild Cognitive impairment, so stated — ICD-10 Code: G31.84

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Amyloid beta (+) pathology confirmation results
  - o Recent MRI prior to initiating Kisunla™ to assess ARIA risk
  - o ApoE 4 Testing Results (If Available)
  - o Completion of cognitive and functional assessments
- Medication List

Patient
Weight: _____ lbs.
Height _____ in.

****Note:** During treatment, conduct an ARIA monitoring MRI before Infusions 2, 3, 4 and 7 and if symptoms consistent with ARIA occur.

KISUNLA™ (donanemab-azbt) J Code: J0175

4. Drug Order:

❑ **New Start Titration:** (3 Total infusions: 4 weeks apart)

Infusion 1: Infuse **350 mg (1 vial)** intravenously over 30 minutes for **one** dose (week 0)
Infusion 2: Infuse **700 mg (2 vial)** intravenously over 30 minutes for **one** dose (week 4)
Infusion 3: Infuse **1050 mg (3 vial)** intravenously over 30 minutes for **one** dose (week 8)

❑ **Maintenance Regimen** Infusion 4 (week 12) and beyond

Infuse **1400 mg (4 vials)** intravenously over 30 minutes once every 4 weeks thereafter

____# Refills (Recommend 11 Refills)

Pre-Medication Orders: _____

No premedication or laboratory monitoring are required per manufacturer

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written — Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**