KISUNLA (donanemab-azbt) ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. **(required)** Allergies: _____

Diagnosis:

- ☐ **Alzheimer's Disease with Early Onset (ICD-10: G30.0)**
- ☐ **Other: _____ ICD-10 Code: _____**
- ☐ **Mild Cognitive Impairment (ICD-10: G31.84)**
- ☐ **Encounter for clinical registry program (ICD-10: Z00.6) **MEDICARE REQUIRED***

THERAPY ORDER

KISUNLA: 350 mg IV for 1st infusion, 700 mg IV for 2nd infusion, 1050 mg IV for 3rd infusion, then 1400 mg IV every four weeks

- **MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th, and 7th infusions**
- **HOLD INFUSION IF MRI IS NOT PERFORMED AT INDICATED INTERVAL**

ADDITIONAL REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ **Patient enrolled in the CMS National Patient Registry (Medicare and Medicare Advantage required)**
  Issue number: _____ Date of registry enrollment: _____
- ☐ **Provide a copy of the CMS national patient registry confirmation**
- ☐ **Confirmed presence of amyloid pathology.** Attach results: Amyloid PET scan OR +CSF (cerebrospinal fluid)
- ☐ **MRI of the brain** (within 1 year) – attach results
- ☐ **Cognitive assessment scores** (list all available, attach results):
  - ☐ **MMSE:** Score _____ Date of assessment _____
  - ☐ **MoCA:** Score _____ Date of assessment _____

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____

Contact Person: _____