# Kisunla™
# Infusion orders

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

## Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Patient Name | | DOB | | Gender | Male ☐ Female ☐ | Weight | ____lbs ☐ kg ☐ |
| SSN | | Phone | | Allergies | | | |
| Address | | City | | State | | Zip Code | |

## Patient Insurance Information

(Or Attach Face Sheet from Patient Chart)

| | | | | | |
|---|---|---|---|---|---|
| Primary Insurance | | Name of the Insured | | Relationship | |
| Member ID# | | Group # | | Insurance Phone # | |
| Secondary Rx Carrier | | Rx ID # | | Rx Group # | |

## 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 2nd, 3rd, 4th, and 7th infusions.

## Kisunla™ (donanemab-azbt) Prescription

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

☐ Standard dosing

| | | |
|---|---|---|
| Infusion 1 | : | Infuse 350 mg IV × 1 |
| Infusion 2 | : | Infuse 700 mg IV × 1, 4 weeks after Infusion 1 |
| Infusion 3 | : | Infuse 1050 mg IV × 1, 4 weeks after Infusion 2 |
| Infusion 4 and beyond | : | Infuse 1400 mg IV every 4 weeks, beginning 4 weeks after Infusion 3 |

☐ Other: _____

Medication will be infused over approximately 30 minutes.
Using a 50 mL 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10–20 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 1st dose, would you like DeliverIT Infusion & Specialty to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:

Epinephrine 0.3 mg (>30 kg), 0.15 mg (15–30 kg), or 0.01 mg/kg (<15 kg) SUBQ or IM × 1; repeat ×1 in 5–15 min PRN.

Diphenhydramine 25 mg (>30 kg) or 1.25 mg/kg (<30 kg) IV or IM; repeat ×1 in 15 min PRN no improvement.

 

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## Ancillary Orders

### Medication Orders

☐ Other: _____

### IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2–3 mL pre-/post-use
- Implanted Port: 0.9% Sodium Chloride 5–10 mL pre-/post-use and 10–20 mL pre-/post-lab draw.
  Heparin (100 unit/mL) 3–5 mL post-use.
  For maintenance, heparin (100 unit/mL) 3–5 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 × 1 year.

If patient is seen within a provider-led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight.
No individual anaphylaxis kit will be dispensed.

## Prescriber Insurance Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Prescriber Name | | NPI# | | Office # | | Fax # | |
| Address | | City | | State | | Zip Code | |

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

*Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.*

Date

Prescriber's Signature

X _____

 