Kisunla (donanemab-azbt)

Provider Order Form *rev. 1/2/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description

☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.8 Other Alzheimer's disease, unspecified
☐ G31.84 Mild Cognitive impairment of uncertain or unknown etiology
☐ Other: _____

If using CMS-approved clinical trial or registry PLEASE SELECT alongside primary diagnosis code:
Z00.6 (encounter for examination for normal comparison and control in clinical research study)

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____
**MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th and 7th infusion

Lab Orders

Required: TB test results, MRI within 1 year
Cognitive Assessment Score_____
Confirmed presence of amyloid pathology
CMS Registry confirmation ALZH _____ (medicare and medicare advantage only)
ApoE ε4 Testing (if available)
Patient has been provided ARIA Risk Counseling
☐ Other: _____

Kisunla (donanemab-azbt) (Select one):

Standard dosing

☐ **Infusion 1:** Infuse 350 mg IV x1
☐ **Infusion 2:** Infuse 700 mg IV x 1, 4 weeks after Infusion 1
☐ **Infusion 3:** Infuse 1050 mg IV x1, 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 50ml 0.9% Sodium Chloride IV bag, flush IV tubing with NS 10 to 20 mL after each infusion.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454