



## Kisunla (Donanemab) Infusion Order

Fax to 801.931.2631 or Email to [intake@purehealthcare.com](mailto:intake@purehealthcare.com)

To ensure swift processing of your order, please complete all fields.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Pt. Sex: \_\_\_\_\_ Pt. Weight: \_\_\_\_\_ kg Pt. Height: \_\_\_\_\_ in Pt. Email (opt): \_\_\_\_\_  
Pt. Status: ☐ New Patient ☐ Continuing Therapy Last Infusion Date (if applicable): \_\_\_\_\_

### DIAGNOSIS DETAILS

- ☐ Alzheimer's Disease with Early Onset (ICD-10 code: G30.0) ☐ Mild cognitive impairment, so stated (ICD-10 code: G31.84)  
☐ 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)

#### AND

- ☐ Clinical research investigation (ICD-10 code: Z00.6), Medicare primary

☐ Other: \_\_\_\_\_ ICD-10 code: \_\_\_\_\_  
Allergies: \_\_\_\_\_

### ORDER DETAILS FOR KISUNLA (DONANEMAB)

#### Kisunla (Donanemab) IV Dosage & Schedule:

- ☐ Dose 1 at 350mg q4 weeks - **MRI needed** ☐ Doses 4 - 6 at 1400mg q4 weeks - **MRI needed**  
☐ Dose 2 at 700mg q4 weeks - **MRI needed** ☐ Doses 7+ at 1400mg q4 weeks - **MRI needed**  
☐ Dose 3 at 1050mg q4 weeks - **MRI needed**

#### Pre-medications:

- ☐ Acetaminophen 650mg PO  
☐ Solu-Medrol 100mg IV  
☐ Diphenhydramine 25mg PO or IV  
☐ Hydrocortisone 100mg IV

- ☐ Methylprednisolone 125mg IV

☐ Other Pre-medications: \_\_\_\_\_

#### Infusion Reaction Protocol:

- ☐ [Pure Infusion Reaction Protocol](#) ☐ Other Reaction Protocol (Please send protocol with order)

### ANCILLARY ORDERS (opt.)

Lab Orders: \_\_\_\_\_

Additional Orders: \_\_\_\_\_

### PROVIDER INFORMATION

Practice Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Contact Ph: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Office Ph: \_\_\_\_\_ Office Fax: \_\_\_\_\_

### PURE INFUSION SUITES PREFERRED LOCATION

City: \_\_\_\_\_ State: \_\_\_\_\_

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