Kisunla (Donanemab) Infusion Order

Fax to 801.931.2631 or Email to 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**

☐ Dose 2 at 700mg q4 weeks – **MRI needed**

☐ Dose 3 at 1050mg q4 weeks – **MRI needed**

☐ Doses 4 – 6 at 1400mg q4 weeks – **MRI needed**

☐ Doses 7+ at 1400mg 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: _____