INFUSION CENTER OF NEW ENGLAND

Checklist for Kisunla (donanemab) Referral

Patient Name: _____ **DOB:** _____ **Date:**_____

Referring Physician: _____**NPI:**_____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
    - Note should include any therapies tried/failed, and must include discussion about Kisunla
    - Medication list and allergies
    - Cognitive assessment and functional assessment with score and interpretation
- ❑ Supporting lab reports/imaging for Kisunla treatment
    - MRI within 1 year of treatment start
    - Confirmation of amyloid beta pathology (LP or PET Scan)
    - ApoE testing to determine ARIA risk
    - CMS Registration (must be completed every 6 months)
- ❑ Durable Power of Attorney for Health Care (DPAHC), if applicable
- ❑ Kisunla Prescribing Order and Indication Checklist (see attached)

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Kisunla (donanemab)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s): _____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV in 50ml over 15min
❑ Other: _____

Lab Orders:

❑ _____

KISUNLA Medication Order:

❑ New start: Kisunla 700mg every 4 weels for 3 infusions, then Kisunla 1400mg every 4 weeks over 30min

❑ Maintenance: Kisunla 1400mg every 4 weeks over 30min

❑ Other: _____

Administration:

- ✓ Hold infusion if no MRI Brain prior to the 2nd , 3rd , 4th and 7th infusion
- ✓ Hold infusion and notify provider if patient experiencing any of the following signs of ARIA:
  - Headache, Confusion, Dizziness, Nausea, Vision Changes, Gait Changes, Seizures
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Patient Name: _____DOB: _____

Leqembi/Kisunla Indication Checklist

INFORMATION REQUIRED FOR TREATMENT INITIATION	
1) **Patient ICD-10** (select all that apply) ❑ G30.0 Alzheimer's disease, early onset ❑ G30.1 Alzheimer's disease, late onset ❑ G30.9 Alzheimer's disease, unspecified ❑ G31.84 Mild cognitive impairment	**Clinical Diagnosis** (select one) ❑ Mild cognitive impairment due to AD ❑ Mild AD Dementia
2) **Cognitive Screening: within 6 months** **Date: _____** Name of Test Used: _____ Score: _____ Interpretation: _____ **Functional Screening: within 6 months** **Date: _____** Name of Test Used: _____ Score: _____	
3) **Confirmation of Amyloid-Beta Pathology:** MUST provide supporting documentation ❑ Amyloid PET Scan Date: _____ Result: _____ ❑ CSF Amyloid Confirmation Date: _____ Result: _____	
4) **Monitoring for Amyloid Related Imaging Abnormalities (ARIA)** ***LEQEMBI/KISUNLA requires brain MRI within 1 year of treatment start date*** ❑ Initial MRI Brain Date: _____ Evidence of ARIA-E ❑ Negative ❑ Positive Evidence of ARIA-H ❑ Negative ❑ Positive 5) **Schedule for MRI Monitoring:** the following is required by Infusion Center of New England ❑ Leqembi: Obtain MRI prior to the 5th, 7th, and 14th infusions ❑ Kisunla: Obtain MRI prior to the 2nd, 3rd, 4th, and 7th infusions	
6) **Is the patient on anticoagulation?** ❑ Yes ❑ No 7) **Is the patient on antiplatelets?** ❑ Yes ❑ No	
8) **Has ApoE testing been performed?** ❑ Yes ❑ No Result: _____	
9) **CMS REGISTRATION NUMBER (REQUIRED)** _____ **Date: _____**	

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671