Prescribing Order: Kisunla (donanemab)

❑ 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:

❑ _____

Medication Order:

❑ Recommended Dosing: Kisunla IV every 4 weeks over 30 minutes at the following titration
- Infusion 1: 350mg
- Infusion 2: 700mg
- Infusion 3: 1050mg
- Infusion 4 -18: 1400mg

Maximum treatment course: 18 total infusions

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

Signature **Date**

Infusion Center of New England
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

INFUSION CENTER OF NEW ENGLAND

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 3rd, 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: _____**	

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