Donanemab-azbt (Kinsula)

Provider Order Form Revised 10/30/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:_____ Patient Name:_____ DOB:_____

ICD-10 code: ☐G30.0 ☐G30.1 ☐G30.8 ☐G31.84 ☐Other:_____

ICD 10 Description:_____

☐NKDA Allergies:_____ Weight (lb/kg)_____ Height:_____

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

PROVIDER INFORMATION

Referral Coordinator Name:_____ Referral Coordinator Email:_____

Ordering Provider:_____ Provider NPI:_____

Referring Practice Name:_____ Phone:_____ Fax:_____

Practice Address:_____ City:_____ State:_____Zip:_____

REFERRING PROVIDER

☐ By checking this box, I acknowledge I am responsible for ordering and reviewing all MRIs required for this therapy. I am responsible for communicating results to the patient/guardian.

Patients will not be scheduled for their appointment prior to receiving clearance confirmation from prescribing physician.

☐ Referring provider has registered patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration. **Patients will not be scheduled without enrollment confirmation.**
(https://qualitynet.cms.gov/alzheimers-ced-registry/submission)
MBI: NCT_____ Issue #: ALZH-_____
Submission Date:_____

NURSING

☒ **Results of follow-MRIs will be required PRIOR to administering the 2nd, 3rd, 4th, and 7th infusion**

☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI

☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every_____
☐ CMP ☐ at each dose ☐ every_____
☐ CRP ☐ at each dose ☐ every_____
☐ Other:_____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

SPECIAL INSTRUCTIONS

PRE-MEDICATION ORDERS

Not typically indicated for this medication.

☐ acetaminophen (Tylenol) ☐500 mg/ ☐650 mg/ ☐1000 mg PO
☐ cetirizine (Zyrtec) 10 mg PO
☐ loratadine (Claritin) 10 mg PO
☐ diphenhydramine (Benadryl) ☐25 mg/ ☐50 mg ☐PO/☐IV
☐ methylprednisolone (Solu-Medrol) ☐ 40 mg/ ☐ 125 mg IV
☐ hydrocortisone (Solu-Cortef) 100 mg IV
☐ Other:_____
Dose:_____ Route:_____
Frequency:_____

THERAPY ADMINISTRATION

☒ **Donanemab-azbr (Kinsula):** Prepared to achieve a final concentration of 4 mg/mL per manufacturer guidelines.

☐ Infusion 1: 350 mg
☐ Infusion 2: 700 mg
☐ Infusion 3: 1050 mg
☐ Infusion 4 and beyond: 1050 mg

Please indicate if patient has received any initial doses:

_____

☐ **Route:** Intravenous
☐ **Rate:** Infuse over 30 minutes
☒ **Frequency:** Every four weeks

☒ Flush with 0.9% sodium chloride after infusion completion
☒ Patient is required to stay for 30-minute observation post infusion
☒ Refills: ☐ Zero/ ☐ for 12 months/ ☐ Other:_____
(If not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

☐ Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

_____ _____ _____
Provider Name (Print) Provider Signature Date