Memorial Healthcare System

DONANEMAB-AZBT (KISUNLA)

PATIENT INFORMATION / REFERRAL STATUS

Referral Status: □ New Referral □ Updated Order □ Order Renewal **Date:** _____

Patient Name: _____ DOB: _____

ICD-10 Code: _____ ICD-10 Description/Diagnosis: _____

Allergies: □ NKDA Allergies: _____ Weight: _____ □ lbs/□ kg Height: _____

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

PROVIDER / PRACTICE INFORMATION

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Referral Coordinator Name: _____ Email: _____ Alternative Phone Number: _____

REFERRING PROVIDER COMMUNICATIONS

□ I have reviewed the prescribing information and medication guide for Kisunla (donanemab-azbt).

□ Provide supporting clinical documentation:

- Confirming presence of amyloid beta pathology prior to initiation.
- Confirming cognitive impairment using a validated tool, such as MMSE, MoCA, or other assessment.

□ Obtain baseline MRI without contrast prior to initiating treatment and prior to 2nd, 3rd, 4th and 7th infusions.

- I, the prescribing provider, am responsible for ordering and reviewing all MRIs of the brain for this patient. By checking this box, I acknowledge that I have obtained and reviewed all MRIs as required by the manufacturer's prescribing information and communicated the results to the patient or his/her legal guardian. Memorial Specialty Infusion Services is safe to proceed with the patient's Kisunla (donanemab-azbt) infusions.

REQUIRED DOCUMENTATION

Referring providers must register patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration prior: https://qualitynet.cms.gov/alzheimers-ced-registry/submission

Attach proof of CMS Registry Confirmation or provide below:

Issue Number: ALZH-_____

Date of Submission: _____

NURSING PROTOCOL COMMUNICATIONS

☒ Provide nursing care, vital signs, monitoring according to Memorial Outpatient Procedures. Establish/maintain IV access and administer medication as ordered. Remove peripheral IV access after infusion completion if applicable. Follow infusion-related/hypersensitivity reactions management according to MHS Outpatient Adverse Reaction Protocol available for review on at mhs.net/services/pharmacy/infusion-services/outpatient-infusion.

☒ Discharge/Follow-up instructions according to Memorial Outpatient Procedures.

LABORATORY ORDERS

□ ***Pregnancy, Urine for females of childbearing potential who have not undergone a hysterectomy:*** Once

□ ***ADmark® ApoE Genotype Analysis and Interpretation (Symptomatic):*** Once

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PRE-MEDICATION ORDERS (30-60 Minutes Prior to Therapy)

☐ Acetaminophen (Tylenol) 650 mg PO

☐ Diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV **OR**

☐ Cetirizine (Zyrtec) or Loratadine (Claritin) 10 mg PO

☐ Methylprednisolone (Solu-Medrol) ☐ 40 mg ☐ 125 mg IV **OR**

☐ Dexamethasone (Decadron) ☐ 8 mg ☐ 20 mg PO

☐ Other: _____ Dose: _____ Route: _____ Frequency/Timing: _____

THERAPY PLAN

Medication Name: Donanemab-aznt (KISUNLA)

Loading Dose:

- 350 mg IV x 1 dose (Week 0)
- 700 mg IV x 1 dose (Week 4)
- 1,050 mg IV x 1 dose (Week 8)

Maintenance Dose (Starting Week 12): 1,400 mg IV every 4 weeks until discontinued

Route: ☒ IV ☐ SQ ☐ IM

Infuse over: ☒ 30 minutes ☐ 1 Hour ☐ 2 Hours ☐ Other:_____

*****Diluent/Volume/Concentration/Special tubing/Filters will be in accordance with the product package insert.*****

☒ Flush with 0.9% sodium chloride at completion per protocol or medication-specific instructions

Additional Administration Instructions:

Stop and Consult provider if patient reports signs/symptoms of ARIA (headache, confusion, visual changes, dizziness, nausea, and gait difficulty) before each infusion. Administer through a dedicated line. Observe for infusion and hypersensitivity reactions during infusion and for at least 30 minutes post infusion. Discontinue infusion if hypersensitivity reaction.

Note to Pharmacy/Comments:

_____

_____

Refills: ☐ Zero ☐ for 12 months ☐ Other:_____

(if not indicated, order will expire one year from date signed)

_____	_____	_____
Provider Name (Print)	***Provider Signature***	***Date***

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Adverse Reaction Management Protocol (Adult)

Observe patient for infusion related and hypersensitivity reactions such as fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

If reaction occurs:

- Stop infusion and assess patient.
- Maintain or establish vascular access if needed
- **Administer emergency medication(s) according to symptoms:**

☒ Acetaminophen 650 mg PO once PRN headache, pain, fever >100.4F, chills or rigors.

☒ Diphenhydramine 50 mg IV once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction **OR**

☒ Diphenhydramine 50 mg IM once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction (if no IV access)

☒ Dexamethasone 10 mg IV once PRN shortness of breath or wheezing **OR**

☒ Dexamethasone 10 mg IM once PRN shortness of breath or wheezing (if no IV access)

☒ Ondansetron 4 mg IV once PRN nausea, vomiting **OR**

☒ Ondansetron 4 mg IM once PRN nausea, vomiting (if no IV access)

- May re-start therapy if appropriate when symptoms resolve. Resume infusion at 50% of the previous rate and increase per manufacturer's guidelines.

If a severe allergic/anaphylactic reaction occurs

- Symptoms are rapidly progressing or continuing after administration of PRN medications and/or signs and symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension)

☒ Notify the Rapid Response / Rescue Alert Team / Blue Alert / 911.

☒ Initiate BLS/ Cardiopulmonary resuscitation if necessary.

☒ Administer Epinephrine 0.3 mg intramuscularly, every 5 MIN PRN rapidly progressing or continuing after administration of PRN medication or signs and symptoms of severe allergic/anaphylactic reaction. Administer every 5-15 minutes as needed preferably in the outer thigh.

☒ Place the patient in a recumbent position, elevate lower extremities.

☒ Continuously monitor vital signs (blood pressure, pulse oximetry, and heart rate).

☒ Contact and notify the referring provider on the day of occurrence once patient is stabilized.

☒ Document reaction in the medical record and complete an incident report once patient is stabilized.