

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

☐ Alzheimer's disease with early onset

ICD-10 Code: G30.0

☐ 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

☐ Mild Cognitive impairment, so stated

ICD-10 Code: G31.84

☐ Other _____

ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Patient's CMS Registry information
- Required Information:
 - Amyloid beta (+) PET scan or lumbar puncture
 - Recent MRI prior to initiating Kisunla to assess ARIA risk
 - ApoE 4 Results (if available)

Height: _____

Weight: _____

Kisunla (donanemab-azbt) Orders:

☐ New Start Titration: to be infused 4 weeks apart

- Infusion 1: Infuse 350 mg intravenously
- Infusion 2: Infuse 700 mg intravenously
- Infusion 3: Infuse 1050 mg intravenously

☐ Maintenance Dose: Infuse 1400 mg IV every 4 weeks for 12 months

*** Note: ARIA monitoring MRIs to be conducted before infusions 2, 3, 4, and 7 and if symptoms of ARIA occur***

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg PO ☐ Loratadine 10 mg PO

☐ Cetirizine 10 mg PO ☐ Other: _____

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and its clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus

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