

# Infusion Order Form

**Patient Information:**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Phone Number**

**Medical Information:**

Primary Diagnosis:

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Alzheimer's disease with early onset | ICD-10 Code: G30.0  |
| <input type="checkbox"/> Alzheimer's disease with late onset  | ICD-10 Code: G30.1  |
| <input type="checkbox"/> Other Alzheimer's disease            | ICD-10 Code: G30.8  |
| <input type="checkbox"/> Alzheimer's disease, unspecified     | ICD-10 Code: G30.9  |
| <input type="checkbox"/> Mild Cognitive impairment, so stated | ICD-10 Code: G31.84 |
| <input type="checkbox"/> 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 it's 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 #:**

Please fax the completed order form and all other requested information to: 601-714-1569

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



Revitalize



Revitalize Locations



InfusionPlus