KISUNLA® (donanemab-azbt)

ProviderOrderForm *rev. 1/25/2026*

IVCARE INFUSION

- ☐ Saint Cloud, FL
- ☐ Lake Mary-Sanford, FL
- ☐ Nashville, TN
- ☐ Gallatin, TN

Patient Information

Referral Status: New Referral Updated Order Order Renewal

CMS Registry Number (If already registered) _____

Patient Name: _____ DOB: _____ Phone: _____

Patient Address: _____ Patient Email: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

ICD-10 Code (required): _____ ICD-10 Description: _____ Last Treatment Date: _____ Last 4 SSN: _____

Provider Information

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Referring Practice Name: _____

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

NURSING

Provide nursing care per IVCare Infusion's Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

CBC	At each dose	Every _____
CMP	At each dose	Every _____
CRP	At each dose	Every _____
CSF or Plasma Biomarkers	_____	

PREMEDICATIONS

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: _____ PO / IV

Dose: _____ Frequency: _____

MEDICATION ORDER

☐ Induction Dose

✓ Kisunla 350mg IV at Week 0, 700mg IV at Week 4, 1050mg IV at Week 8, followed by 1400mg IV every 4 weeks thereafter.

Each infusion to be given over approximately 30 minutes.

Required Documentation to Initiate this Phase:

✓ MRI of brain within one year prior to first infusion.

✓ Date of MRI: _____

By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.

☐ Maintenance Dose

✓ Kisunla 1400mg IV every 4 weeks.

Each infusion to be given over approximately 30 minutes.

SPECIAL INSTRUCTIONS:

Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

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

Email: info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to location fax

TN

NASHVILLE
5501A NEW YORK AVE, NASHVILLE, TN. 37209
P: 615-475-5657 F: 615-475-5680

GALLATIN
710 NASHVILLE PIKE, STE 103, GALLATIN, TN. 37066
P: 615-471-8673 F: 615-471-8674

FL

ST. CLOUD
2801 13TH STREET, ST. CLOUD, FL. 34769
P: 407-477-2345 F: 615-471-8674

LAKE MARY - SANFORD
344 W. LAKE MARY BLVD, SANFORD, FL. 32773
P: 407-477-2345 F: 615-471-8674