Kisunla™ (donanemab-azbt) Referral Form

Patient Preferred Clinic (select one):



PATIENT INFORMATION	Referral Status:	New Referral	Updated Order	Order Renewal	
DOB: Patient Name:	Patient Phone:				
Patient Address:			Patient Email:		
NKDA Allergies:		Wei	ght (lbs/kg):	Height:	
ICD-10 code (required): ICD-10 description:		Last Treatment Date: Last 4 SSN:		Last 4 SSN:	
PROVIDER INFORMATION					
Referral Coordinator Name:	Referral Coordinator Email:				
Ordering Provider:	Provider NPI:				
Referring Practice Name:	Phone:		Fax:		
Practice Address:	City:		State: Zip	Code:	
NURSING	KISUNLA THE	RAPY ADMINIS	TRATION		
☐ Infusion to be administered per Vivo protocols. LABORATORY ORDERS CBC At each dose Every	700 mg IV every 4 weeks x 3 doses, followed by 1400 mg every 4 weeks				
CMP At each dose Every CRP At each dose Every Other	**MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th and 7th infusion**				
REQUIRED DIAGNOSIS (Select one)	REQUIRED DOCUMENTATION: ** Patient must be registered with CMS prior to treatment https://qualitynet.cms.gov/alzheimers-ced-registry/submission				
Mild Cognitive Impairment Due to Alzheimer's Diseas	e- G31.84				
Early Onset Alzheimer's Disease – G30.0	Patient Demographics Insurance Card/Information				
Late Onset Alzheimer's Disease – G30.1	_	Progress Notes Supporting DX Current Medication List and H&P			
Other Alzheimer's Disease – G30.8	Cognitive Assessment Score(MMSE 20-28, CDR-GS 0.5 or 1				
Alzheimer's Disease unspecified-G30.9	MRI Within 1 Year Confirmed presence of amyloid pathology (+CSF or amyloid PET scan) CMS Registry Confirmation Email				
	-	ε4 Testing (if availa nt has been provide	ble) d ARIA Risk counseli	ing	
Provider Name (Print) Provid	er Signature				

Fax Numbers

Colorado: 303-418-4679 Nevada: 702-489-5744 Connecticut: 203-724-4838 New Jersey: 800-540-1852

Florida: 904-930-4211 New York: 800-540-1852
Massachusetts: 800-540-1852 Ohio: 216-400-0674

Oklahoma: 918-770-4421

Have a Question? (720) 902-4111

Pennsylvania: 215-399-9244 **Email Referrals To: referrals@vivoinfusion.com** Texas: 469-340-0044

Virginia: 804-500-5941