Kisunla™ (donanemab-azbt) Referral Form

Preferred Clinic (select one): _____

VIVO infusion®

PATIENT INFORMATION

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Infusion Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC w/ diff every _____
☐ CMP every _____
☐ OTHER _____

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

PREMEDICATIONS (please write in): _____

DIAGNOSIS

☐ Mild Cognitive Impairment Due to Alzheimer's Disease– G31.84

☐ Early Onset Alzheimer's Disease – G30.0

☐ Late Onset Alzheimer's Disease – G30.1

☐ Other Alzheimer's Disease – G30.8

☐ Alzheimer's Disease unspecified-G30.9

** Medicare patients must be registered with CMS prior to treatment: https://qualitynet.cms.gov/alzheimers-ced-registry/submission

KISUNLA ADMINISTRATION

****MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th and 7th infusion

☐ Administer every 4 weeks:

- First dose: 350 mg IV
- Second dose: 700 mg IV
- Third dose: 1,050 mg IV
- 4th dose and beyond: 1,400 mg IV

☐ 1,400 mg IV every 4 weeks

REQUIRED DOCUMENTATION:

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Cognitive Assessment Score _____ (MMSE 20-28, CDR-GS 0.5 or 1)**
☐ **MRI Within 1 Year**
☐ **Confirmed presence of amyloid pathology**
☐ **CMS Registry Confirmation ALZH-_____ (Medicare and Medicare Advantage only)**
☐ **ApoE ε4 Testing (if available)**
☐ **Patient has been provided ARIA Risk counseling**

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

Email Referrals To: referrals@vivoinfusion.com OR Fax Below **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	