



**PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER**

- Patient Demographics  
  Insurance card  
  Progress Notes supporting DX  
  Baseline Brain MRI  
  Cognitive assessment score  
 Documented evidence of beta-amyloid plaque on the brain (PET, CSF, Lumbar, Blood test)

**PATIENT**

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kg

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Allergies: \_\_\_\_\_  NKDA

**Patient status:**  
  New to therapy  
  Continuing therapy  
 Last Treatment Date: \_\_\_\_\_  
 Next Treatment Date: \_\_\_\_\_

**DIAGNOSIS ICD-10 code (must be specified)**

- Alzheimer's Disease G30.9  
  Alzheimer's Disease G30.0  
 Alzheimer's Disease G30.1  
  Other Alzheimer's Disease G30.8  
 Mild cognitive impairment G31.84

**REGISTRY NUMBER – (required for patients with Medicare)**

Registry Number: \_\_\_\_\_

**PROVIDER**

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Referral Coordinator Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**PRE-MEDICATION**

- Acetaminophen (Tylenol) PO  
  500 mg  
  650 mg  
  1000 mg  
 Diphenhydramine (Benadryl)  
  PO  
  IV  
  25 mg  
  50 mg  
 Methylprednisolone (Solu-Medrol) IV  
  40 mg  
  125 mg  
 Cetrizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_

**THERAPY ADMINISTRATION**

Medication	Dose	Frequency
<input checked="" type="checkbox"/> Kisunla (Donanemab-AZBT), IV	<input checked="" type="checkbox"/> 700 mg every four weeks for the first three doses, followed by 1400 mg every four weeks.	<input checked="" type="checkbox"/> Every 4 weeks
Refills <input type="checkbox"/> Zero <input type="checkbox"/> 12 months <input type="checkbox"/> _____	Order valid for 1 year unless otherwise stated. _____	
<input checked="" type="checkbox"/> Infuse over 30 minutes.		
<input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at infusion completion.		
<input checked="" type="checkbox"/> Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.		
*Referring provider is responsible for obtaining an MRI prior to the 2nd, 3rd, 4th, and 7th infusions		

**LABORATORY ORDERS**

- CBC  
  at each dose  
  every \_\_\_\_\_  
 CMP  
  at each dose  
  every \_\_\_\_\_  
 CRP  
  at each dose  
  every \_\_\_\_\_  
 Other

**SPECIAL INSTRUCTIONS**

\_\_\_\_\_

Provider Signature

Date