Ascension Rx

Donanemab-azbt (Kisunla & Biosimilars) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

☐ Labs to be reviewed or ordered by infusion center

- ☐ Baseline
  - ☑ CBC with Differential
  - ☑ CMP
- ☐ Maintenance (every _____)
  - ☑ CBC with Differential
  - ☑ CMP

☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)

☐ Other: _____ ☐

Provider Information

Obtain a recent baseline brain MRI prior to initiating treatment and prior to the 2nd, 3rd, 4th, and 7th infusions.

Amyloid related imaging abnormalities (ARIA): Enhanced clinical vigilance for ARIA is recommended during the first 24 weeks of treatment with Donanemab. Risk of ARIA, including symptomatic ARIA, was increased in apolipoprotein E ε4 (ApoE ε4) homozygotes compared to heterozygotes and noncarriers. The risk of ARIA-E and ARIA-H is increased in Donenab-treated patients with pretreatment microhemorrhages and/or superficial siderosis. If a patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed, including MRI scanning if indicated.

Live vaccines should not be given concurrently

Required Billing Permanent Clinical Trial Number: 06058234
MEDICARE Patients Only: CMS Registry Enrollment

- ☐ Medicare Beneficiary ID (MBI):_____
- ☐ CED Study Identification (NCT): _____
- ☐ CED Study Identification (ALZH): _____

Nursing Orders

☑ Verify MRI is done prior to initiating treatment and 2nd, 3rd, 4th, and 7th infusions. Notify the provider if not done prior to infusion.

☑ Verify patient is not experiencing symptoms of Amyloid related imaging abnormalities (ARIA) such as headache, dizziness, nausea, confusion, vision changes, seizures, and difficulty walking prior to infusion.

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- [x] Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- [x] Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- [ ] Acetaminophen 650 mg PO once
- [ ] Diphenhydramine 25 mg PO once
- [ ] Diphenhydramine 25 mg IV once
- [ ] Diphenhydramine 50 mg PO once
- [ ] Diphenhydramine 50 mg IV once
- [ ] Famotidine 20 mg IV once
- [ ] Famotidine 20 mg PO once
- [ ] Dexamethasone 20 mg IV once
- [ ] Dexamethasone 20 mg PO once
- [ ] Methylprednisolone 125 mg IV once
- [ ] Methylprednisolone 40 mg IV once
- [ ] Other: _____

IV Site Orders

- [x] Follow standard protocol for IV site management
- [x] In absence of standard protocol, follow the orders below:
  - [x] Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - [x] Start peripheral IV or access central line for infusion
  - [x] Sodium chloride 0.9% 10 mL flush to IV site as needed
  - [x] Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - [x] Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - [x] May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders

Loading Dose

- [ ] Donanemab 350 mg IV once over 30 minutes on Week 0, 700 mg on Week 4, and 1050 mg on week 8

Maintenance Dose

- [ ] Donanemab 1400 mg IV once over 30 minutes every 4 weeks

Refills:
(Refills for one year from date of signature unless indicated)

- [ ] Zero
- [ ] For 12 months
- [ ] _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- [ ] Payer-mandated substitution
- [ ] Financial stewardship
- [ ] Patient access / hardship

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Pharmacy may adjust dose ±10% of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Monitor patients for 30 minutes after each infusion.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated