GREATER BOSTON INFUSION CENTER
17/19 Kendrick St, Wrentham, MA 02093
P 774-581-0032 | F 774-581-0033

Kisunla - Referral Checklist

Referral packet checklist Complete this page and attach the supporting items below.

PATIENT & REFERRING PROVIDER

PATIENT NAME | DOB | DATE

REFERRING PROVIDER | NPI | DIRECT CONTACT / EXT.

OFFICE / PRACTICE | PHONE | FAX

EMAIL | URGENT CLINICAL CONTACT

REQUIRED REFERRAL PACKET

- [ ] Patient demographics and contact information
- [ ] Primary and secondary insurance information; front/back card copies
- [ ] Supporting clinical notes / office visits documenting Kisunla treatment plan
- [ ] Current medication list and allergies
- [ ] Relevant laboratory results / imaging and baseline safety information
- [ ] Completed Kisunla prescribing order (following page)

MEDICATION-SPECIFIC CLINICAL DOCUMENTATION

- Note should include any therapies tried/failed, and must include discussion about Kisunla
- Medication list and allergies
- Cognitive assessment and functional assessment with score and interpretation
- MRI within 1 year of treatment start

GBIC INTERNAL USE

REFERRAL RECEIVED | BENEFITS VERIFIED | PA STATUS / THROUGH | SCHEDULED

Prescribing Order - Kisunla (donanemab)

☐ New Start ☐ Maintenance DATE OF LAST DOSE / INFUSION

ORDER DETAILS

DATE OF ORDER | PATIENT NAME | DOB | M/F

DIAGNOSIS / ICD-10 ☐ NKDA PATIENT WEIGHT

ALLERGIES

PREMEDICATIONS

- ☐ Acetaminophen 1000mg PO
- ☐ Loratadine 10mg or Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Diphenhydramine 25mg IV
- ☐ Solu-medrol 125mg IV in 50ml over 15min
- ☐ Other

LAB ORDERS

☐

Prescribing Order - Kisunla (donanemab) (continued)

KISUNLA MEDICATION ORDER:

☐ Recommended Loading Dosing: Kisunla IV every 4 weeks at the following titration

- Infusion 1: 350mg
- Infusion 2: 700mg
- Infusion 3: 1050mg
- Infusion 4 and beyond: 1400mg

☐ Maintenance: Kisunla 1400mg every 4 weeks over 30 min

☐ Other

ADMINISTRATION & MONITORING

- ✓ Hold infusion if no MRI Brain prior to the 2nd , 3rd , 4th and 7th infusion
- ✓ Hold infusion and notify provider if patient experiencing any of the following signs of ARIA:
- ✓ Headache, Confusion, Dizziness, Nausea, Vision Changes, Gait Changes, Seizures
- ✓ In case of infusion reaction, STOP infusion and follow GBIC infusion reaction protocol. Notify physician.
- ✓ Signature Date

PROVIDER AUTHORIZATION

ORDERING PROVIDER NAME | **NPI** | **DATE**

SIGNATURE | **OFFICE PHONE / EXT.**

Handwritten or compliant electronic signature

Kisunla - Additional Clinical Checklist

PATIENT IDENTIFICATION

PATIENT NAME

DOB

CLINICAL INFORMATION

INFORMATION REQUIRED FOR TREATMENT INITIATION

1. PATIENT ICD-10 (SELECT ALL THAT APPLY) CLINICAL DIAGNOSIS (SELECT ONE)

- ☐ G30.0 Alzheimer's disease, early onset ❑ Mild cognitive impairment due to AD
- ☐ G30.1 Alzheimer's disease, late onset ❑ Mild AD Dementia
- ☐ G30.9 Alzheimer's disease, unspecified
- ☐ G31.84 Mild cognitive impairment

2. COGNITIVE SCREENING: WITHIN 6 MONTHS DATE: _____

Name of Test Used

Interpretation

Functional Screening: within 6 months Date

3. CONFIRMATION OF AMYLOID-BETA PATHOLOGY: MUST PROVIDE SUPPORTING DOCUMENTATION

- ☐ Amyloid PET Scan Date
- ☐ CSF Amyloid Confirmation Date

4. MONITORING FOR AMYLOID RELATED IMAGING ABNORMALITIES (ARIA)

LEQEMBI/KISUNLA requires brain MRI within 1 year of treatment start date

- ☐ Initial MRI Brain Date

Evidence of ARIA-E ❑ Negative ❑ Positive

Evidence of ARIA-H ❑ Negative ❑ Positive

- ☐ Leqembi: Obtain MRI prior to the 5th, 7th, and 14th infusions
- ☐ Kisunla: Obtain MRI prior to the 2nd, 3rd, 4th, and 7th infusions

Kisunla - Additional Clinical Checklist (continued)

8. HAS APOE TESTING BEEN PERFORMED? ❑ YES ❑ NO

Result

9. CMS REGISTRATION NUMBER

(REQUIRED)