

McLeod Health

Donanemab-azbt (Kisunla) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one):

- G30.0 Alzheimer's disease with early onset G30.1 Alzheimer's disease with late onset
 G30.8 Other Alzheimer's disease G31.84 MCI of uncertain etiology
 Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

- None
 Acetaminophen 650 mg PO
 Diphenhydramine: Dose: 25 mg 50 mg Route: PO or IVP
 Methylprednisolone: Dose: 40 mg or 125 mg Route: IVP
 Famotidine: Dose: 20 mg Route: PO or IVPB
 Other (include drug, dose, and route): _____

Drug Orders:

- Donanemab (Kisunla) (J0175) in 100 mL Sodium Chloride 0.9% IV to infuse over 30 minutes once every 4 weeks
 Week 0: 350 mg
 Week 4: 700 mg
 Week 8: 1050 mg
 Week 12 and thereafter: 1400 mg
- Order Duration: One year unless otherwise specified (Other: _____)

Standing Orders:

- Monitor patient for 30 minutes following completion of infusion.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.
- Appropriate access and line care orders per health system policy

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Baseline MRI required prior to treatment initiation; physician responsible for follow up imaging per package insert
- Amyloid beta pathology status and Apolipoprotein E e4 status confirmed prior to treatment initiation

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received donanemab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____ and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

- McLeod Regional Medical Center (Florence) McLeod Health Loris McLeod Health Cheraw
- McLeod Health Seacoast (Little River) McLeod Health Dillon McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.