Please fax all pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Kisunla™ (donanemab-azbt)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is the patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____

Patient wt _____ Date wt obtained _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

Diagnosis:

- ☐ G30.0 Alzheimer's disease with early onset
- ☐ G30.1 Alzheimer's disease with late onset
- ☐ G30.8 Other Alzheimer's disease
- ☐ G30.9 Alzheimer's disease, unspecified
- ☐ G31.84 Mild cognitive impairment, so stated
- ☐ Other: _____

Date of last MRI negative for ARIA: _____

Evidence of amyloid positivity confirmed via:

- ☐ PET scan
- ☐ CSF sample
- ☐ Plasma sample
- ☐ Date: _____

4 Prescribing Information

Medication/Strength	Directions	Quantity/Refills
☐ Kisunla™ (donanemab-azbt) 350mg/20mL (17.5mg/mL) single-dose vial **Medicare beneficiaries (required by CMS):** NCT registry number: _____ CED submission number: _____ CED submission date: _____ CED Registry Link: **https://qualitynet.cms.gov/alzheimers-ced-registry**	☐ **Starting Dose:** Infuse 700mg (two vials) intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3 If patient needs partial starting dose, indicate what is needed: ☐ Infusion 2 and Infusion 3 ☐ Infusion 3 only	2 vials/28 days supply Refills: ☐ 2 ☐ Other _____
	☐ **Maintenance Dose:** Infuse 1400mg (four vials) intravenously over approximately 30 minutes at infusion 4 and then once every 4 weeks thereafter	4 vials/28 days supply Refills: ☐ Other _____
	• Observe the patient post-infusion for a minimum of 30 minutes to evaluate for infusion reactions and hypersensitivity reactions. Note: MRIs must be obtained by prescriber prior to initial infusion and before Infusions 2, 3, 4 and 7 to monitor for ARIA, and as needed if symptoms consistent with ARIA occur.	

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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