| St. Charles Health System<br><br>Adult Ambulatory Infusion Order<br>Donanemab-azbt (KISUNLA) | Patient Name:<br>Date of Birth:<br><br>*Patient Identification* |
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**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE**

**Treatment Start Date: _____ Allergies: _____**
**Weight: _____kg Height: _____ cm**

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**
**1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
**2. Recent VISIT NOTE to support treatment (if not available in Epic)**
**3. LAB RESULTS for any required prescreening (if not available in Epic)**
**4. DIAGNOSIS CODE _____**
**5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**GUIDELINES FOR ORDERING**

1. Confirm the presence of amyloid beta pathology prior to initiating treatment (e.g. CSF assessment or PET scan).
2. Obtain a recent (within one year) brain MRI prior to initiating treatment to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA).
3. Obtain an MRI prior to the 2nd, 3rd, 4th, and 7th infusions. If radiographically observed ARIA occurs, treatment recommendations are based on type, severity, and presence of symptoms.
4. Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment with donanemab. If patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed, including MRI if indicated. If ARIA is observed on MRI, careful clinical evaluation should be performed prior to continuing treatment.
5. Apolipoprotein E (ApoE ε4) genotyping should be assessed prior to treatment initiation and inform risk for development of ARIA.

**NURSING ORDERS:**

1. Monitor for infusion reactions during infusion and observe for at least 30 minutes following infusion.
2. Confirm an MRI was performed prior to the 2nd, 3rd, 4th, and 7th infusions.
3. Hold infusion and notify provider if patient reports: Headache, dizziness, vision changes, or new/worsening confusion.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solutions, declotting (alteplase), and/or dressing changes.

**PRE-MEDICATIONS:** (Administer 30 minutes prior to infusion)
**Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)**

☐ Acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION, every visit

☐ DiphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION every visit. Give either diphenhydrAMINE or loratadine, not both.

☐ Loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION and diphenhydrAMINE is not given, every visit. Give either loratadine or diphenhydrAMINE, not both.

☐ Dexamethasone (DECADRON), 10 mg, intravenous, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION, every visit.

**MEDICATIONS:**

Note: Only one stage of treatment may be ordered at a time, this ensures required MRI scans have been completed and read by ordering provider.

**Stage 1 (Infusion #1):**

donanemab-azbt (KISUNLA) in sodium chloride 0.9%, intravenous, ONCE

☐ Initiation Treatment 1: 350 mg once, starting now

**Required Documentation to Initiate this Phase:**

☐ MRI of brain within one year prior to first infusion.

Date of MRI: _____

By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.

**Stage 2 (Infusion #2):**

☐ Initiation Treatment 2: 700 mg once, starting 4 weeks after Initiation Treatment 1

**Required Documentation to Initiate this Phase:**

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #2. I have reviewed the results and clear the patient to proceed with infusion #2.

**Stage 3 (Infusion #3):**

☐ Initiation Treatment 3: 1050 mg once, starting 4 weeks after Initiation Treatment 2

**Required Documentation to Initiate this Phase:**

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #3. I have reviewed the results and clear the patient to proceed with infusion #3.

**Stage 4 (Infusions #4-6):**

☐ Maintenance: 1400 mg every 4 weeks x 3 doses, beginning 4 weeks after Initiation Treatment 3

**Required Documentation to Initiate this Phase:**

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #4. I have reviewed the results and clear the patient to proceed with infusion #4, #5, and #6.

**Stage 5 (Infusion #7 and Beyond):**

☐ Maintenance: 1400 mg every 4 weeks, beginning 4 weeks after Initiation Treatment #6

**Required Documentation to Initiate this Phase:**

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #7. I have reviewed the results and clear the patient to proceed with infusions #7 and beyond as ordered above.

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

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**Plan will expire 1 year after signature date at which time a new order will need to be placed**