



JUPITER
INFUSION

Jupiter Infusion
140 Jupiter Lakes Blvd, Suite A
Jupiter, FL 33458
Office: 561-277-9211

KISUNLA (donanemab-azbt) ORDER FORM
P: 561 277 9211 F: 561 277 9226

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561 277 9226

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy Next Treatment Date: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Diagnosis:

- Alzheimer’s Disease with Early Onset (ICD-10: G30.0)
- Other: _____ ICD-10 Code: _____
- Mild Cognitive Impairment (ICD-10: G31.84)
- Encounter for clinical registry program (ICD-10: Z00.6) ****MEDICARE REQUIRED***

THERAPY ORDER

- KISUNLA: 350mg IV for first infusion followed by 700mg IV for 2nd infusion, 1050mg IV for 3rd infusion, 1400mg IV for 4th infusion and every infusion thereafter every 4 weeks
 - MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th, and 7th infusions
 - HOLD INFUSION IF MRI IS NOT PERFORMED AT INDICATED INTERVAL

ADDITIONAL REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Patient enrolled in the CMS National Patient Registry (Medicare and Medicare Advantage required)
Issue number: _____ Date of registry enrollment: _____
- Provide a copy of the CMS national patient registry confirmation
- Confirmed presence of amyloid pathology. Attach results: Amyloid PET scan OR +CSF (cerebrospinal fluid)
- MRI of the brain (within 1 year) – attach results
- Cognitive assessment scores (list all available, attach results):
 - MMSE: Score _____ Date of assessment _____
 - MoCA: Score _____ Date of assessment _____

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____

Contact Person: _____