Clearwell Infusion Centers

Phone: (305)306-7147
Fax: (305)402-9559
Email: intake@clearwellinfusion.com

KISUNLA (Donanemab-azbt)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ Baseline brain MRI prior to initiating treatment
☐ MRI prior to the 2nd, 3rd, 4th, and 7th infusions

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Dosage and Frequency

☐ Dose 1 at 700 mg- **MRI needed**
☐ Dose 2 at 700 mg- **MRI needed**
☐ Dose 3 at 700mg - **MRI needed**
☐ Doses 4-6 at 1400mg every 4 weeks- **MRI needed**
☐ Doses 7+ at 1400mg every 4 weeks- **MRI needed**

Patient Weight:

_____ lbs
_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____