

# 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) 700 mg per 100 mL Sodium Chloride 0.9% IV to infuse over 30 minutes once every 4 weeks for 3 doses followed by donanemab 1400 mg per 100 mL Sodium Chloride 0.9% IV to infuse over 30 minutes every 4 weeks
- 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.

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](mailto:medicationaccessteam@mcleodhealth.org).**