BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ____/___/___

Date of Last Infusion: _____/_____/_____ Height _____ Weight _____

Allergies: _____ Infusion Location (state and site):

_____

Kisunla (donanemab-azbt) Infusion Orders

Diagnosis

❑ Alzheimer's Disease: G30.9	❑ Alzheimer's Disease with Late Onset: G30.1
❑ Other Alzheimer's Disease: G 30.8	❑ Alzheimer's Disease with Early Onset: G 30.0

Premedication:

❑ Tylenol 500 mg PO	❑ Cetirizine (Zyrtec) 10 mg PO
❑ Famotidine 20 mg IV	❑ Benadryl 25 mg PO
❑ Methylprednisolone (SoluMedrol) 125 mg IVP	❑ Other_____

Medication:

❑ **Kinsula** 700 mg IV every four weeks for the first three doses, followed by 1400 mg every four weeks.	
❑ New Start Therapy	❑ Continuation of Therapy
Date of Last Dose (if applicable)_____	

Labs/Specialty Instructions:

Provider Name (print):_____ Date:_____

Provider Signature: _____ Time:_____

Reviewed 1/6/25. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability