Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Donanemab-azbt (KISUNLA) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING:

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Confirm the presence of amyloid beta pathology prior to initiating treatment.
3. Obtain a recent (within one year) brain MRI prior to initiating treatment to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA).
4. Obtain an MRI prior to the 2nd, 3rd, 4th, and, 7th donanemab-azbt infusions. If radiographically observed ARIA occurs, treatment recommendations are based on type, severity, and presence of symptoms.
5. Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment with donanemab-azbt. If a 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.

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. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE AS NEEDED for prior infusion reaction
- ☐ diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, ONCE AS NEEDED for prior infusion reaction ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED for prior infusion reaction if diphenhydrAMINE is not given. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ dexamethasone (DECADRON), 10 mg, intravenous, ONCE AS NEEDED for prior infusion

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MEDICATIONS:

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

- ☐ Initiation Treatment 1: 350 mg once, starting now
- ☐ Initiation Treatment 2: 700 mg once, starting 4 weeks after Initiation Treatment 1
- ☐ Initiation Treatment 3: 1050 mg once, starting 4 weeks after Initiation Treatment 2
- ☐ Maintenance: 1400 mg every 4 weeks, beginning 4 weeks after Initiation Treatment 3
- ☐ _____

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610