Horizon Infusions

kisunla™ (donanemab-azbt)

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Lima
- ☐ Mansfield
- ☐ Mentor
- ☐ Perrysburg
- ☐ Sandusky
- ☐ Solon
- ☐ Springfield
- ☐ Toledo
- ☐ Troy
- ☐ Warren
- ☐ Youngstown
- ☐ Zanesville
- ☐ Crestview Hills (KY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name: | **DOB:**

Phone: | **Other Phone:**

Email:

Social Security #: | **Allergies:**

Gender: ☐ M ☐ F | **Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name: | **NPI#:**

License #: | **TIN#:** | **DEA#:**

Address:

City: | **State** | **Zip**

Office Contact: | **Email:**

Office phone: | **Office fax:**

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ **Alzheimer's Disease (_____)** ☐ **Other: _____**

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

Referring provider is responsible for obtaining an MRI prior to infusions #1, #2, #3, #4, and #7.

CMS Registry Letter Received and Attached

☐ Yes ☐ No

Registry Trial Number: NCT06058234

☐ **Other _____**

☐ **Administer over approximately 30 minutes Q4 weeks:**

- **Infusion 1: 350mg**
- **Infusion 2: 700mg**
- **Infusion 3: 1050 mg**

☐ **Infusion 4 and beyond: 1400mg**

☐ **Vital signs per HI protocol**

☐ **Anaphylaxis & Hydration Management per HI protocol**

PRE-MEDICATIONS ☐ **N/A**

- ☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**
- ☐ **Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)**
- ☐ **Diphenhydrimine (Benadryl)** ☐ **25mg** ☐ **50mg** ☐ **PO** ☐ **IV** (requires driver)
- ☐ **Methylprednisolone (Solu-Medrol)** ☐ **40mg** ☐ **80mg** ☐ **125mg IV**
- ☐ **Prednisone _____ mg PO**
- ☐ **Other _____**

POST-MEDICATIONS ☐ **N/A**

- ☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**
- ☐ **Prednisone _____ mg PO**
- ☐ **Other _____**

6. LABS

☐ **CBC w/Diff**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CRP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CMP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **ESR**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Hepatic Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Renal Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**

☐ **Quantiferon TB Gold, annually, last completed *(date)*: _____**

Other (*specify*):_____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE | **DATE**