Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Donanemab-azbt (KISUNLA) Infusion** Page 1 of 3	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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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders