Lilly Support Services™

CARE COORDINATION FORM
Kisunla™ (donanemab-azbt)
injection for IV infusion

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PUBLISHED 01/2025

OFFICE: Complete the entire form and submit to Lilly Support Services™ via fax at 1-844-731-2697.
For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Background: The Care Coordination form is to be completed by Healthcare Providers (HCPs) or their supporting office staff who have previously enrolled a Patient in Lilly Support Services™ and selected the Care Coordination service. The form can be completed manually and sent to Lilly Support Services™ via 1-844-731-2697. Lilly Support Services™ will review the form and provide a copy of the completed form to the Patient's Infusion Center. Lilly Support Services™ will reach out to your office with any questions.

Instructions: Sections one and two of the Care Coordination Form must be completed every time the form is submitted to Lilly Support Services™. Sections three, four, and five should be completed when appropriate, as directed in the instructions at the top of each section.

Note: At Infusion 4, the full Prescribing Information recommends that a Patient's dose be adjusted to 1400mg.

Section 1: Patient and HCP Information

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

Infusion History:

☐ **Patient has not yet started treatment**

☐ **Patient's Last Infusion # of Kisunla™ (e.g., Infusion 1, Infusion 2, etc.)** _____ **Last Infusion Date** _____

HCP First and Last Name _____

HCP NPI# _____ **HCP Practice Name** _____

Section 2: Patient Status

Patient Status:

☐ Treatment Paused ☐ Patient has completed therapy ☐ Continue Treatment ☐ Patient has not yet started treatment

Note: If treatment has been paused and subsequently resumes, please contact Lilly Support Services™ at 1-800-LillyRx (1-800-545-5979) to discuss the resumption of Lilly Support Services™ for your Patient.

Section 3: Amyloid Pathology

Additional Instructions: Healthcare Providers enrolled in Care Coordination must provide confirmation of amyloid pathology prior to their Patient's first infusion. If you are initiating treatment for your Patient, please complete this section. Note: if your Patient is amyloid negative, Kisunla™ is not a treatment option and completion of this form is not required.

Amyloid pathology confirmed via:

☐ Amyloid PET Scan **OR** ☐ CSF analysis **OR** ☐ Blood plasma Date: _____

Result: Please check the box to confirm the Patient was determined to be amyloid positive ☐ Amyloid Positive

Section 4: MRI Information

Additional Instructions: Kisunla can cause amyloid related imaging abnormalities -edema (ARIA-E) and -hemosiderin deposition (ARIA-H). Enhanced clinical vigilance for ARIA is recommended during the first 24 weeks of treatment with KISUNLA. Risk of ARIA, including symptomatic ARIA, was increased in apolipoprotein E ε4 (ApoE ε4) homozygotes compared to heterozygotes and noncarriers. The risk of ARIA-E and ARIA-H is increased in KISUNLA-treated Patients with pretreatment microhemorrhages and/or superficial siderosis. If a Patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed, including MRI scanning if indicated. *[See full prescribing information for complete boxed warning]*

As set forth in Section 2.3 of Kisunla's Prescribing Information, Health Care Providers should obtain a recent baseline brain magnetic resonance imaging (MRI) prior to initiating treatment with Kisunla and prior to the 2nd, 3rd, 4th, and 7th Infusions. If a Patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed by the HCP, including an MRI if indicated.

Healthcare Providers enrolled in Care Coordination may elect to provide the Patient's MRI completion date for ARIA monitoring. If you are initiating treatment for your Patient or your Patient has just completed Infusion 1, 2, 3, or 6, please complete this section.

MRI Obtained by Healthcare Provider On _____

Note: If the Healthcare Provider determines that a Patient should not proceed with the next infusion for any reason, please consult the full Prescribing Information and ensure the appropriate Patient Status is also selected in Section 2: Patient Status. If the Healthcare Provider determines that the Patient should proceed with the next infusion, please ensure the "Continue Treatment" option is also selected in Section 2: Patient Status.

Section 5: CED Registry and Clinical Assessment Information

Additional Instructions: For Medicare insured Patients, an updated CMS approved Coverage with Evidence Development (CED) Registry submission is required before treatment initiation and every 6 months thereafter, prior to the Patient's next infusion.
If you are initiating treatment for your Patient or if it has been 6 months since your previous CED Registry submission on behalf of your Patient, please complete this section.

Cognitive Assessment Completed:

☐ MMSE ☐ MoCA ☐ CDR ☐ Other _____ **Completion Date** _____

Functional Assessment Completed:

☐ FAQ ☐ FAST ☐ Other _____ **Completion Date** _____

Party responsible for completing the CED Registry:

☐ HCP Office ☐ Infusion Center ☐ Other _____

ClinicalTrials.gov Registry Number: NCT (Numeric 8 digits) _____

CED Registry Initial/Update Submission Date _____

CED Registry Initial/Update Submission Number (if applicable to completed registry (e.g., CMS Registry uses ALZH-#####)) _____

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