The Lilly Cares® Foundation Patient Assistance Program ("Lilly Cares")

Prescription FAX Form

Kisunla™ (donanemab-azbt) injection for IV infusion 350 mg/20 mL (17.5 mg/mL)

Patient Information:

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Ship to (if different from patient address above, No P.O. Box or third-party vendor)**:**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Drug Allergies: _____

Other Medications: _____

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy. To submit an electronic prescription, please select Fortrea Specialty Pharmacy (NPI 1780811125) in your eRx software.

Please indicate patient's treatment plan (by check mark):

Type of Last Kisunla Treatment (Select ONE)	Kisunla Dosing Phase	Directions	Quantity	Refills
☐ Not started yet Anticipated Infusion Date: _____	☐ Starting Dose: 700 mg intravenously	700 mg intravenously over approximately 30 minutes once every 4 weeks for infusions 1, 2, and 3	1 month	
☐ Infusion 2 ☐ Infusion 3 ☐ Infusion 4+	☐ Maintenance Dosing: 1400 mg intravenously	1400 mg intravenously over approximately 30 minutes once every 4 weeks	1 month	

Your state may require that prescriptions follow certain content requirements or use a particular form. Non-compliance with state-specific requirements will result in outreach to the prescriber and may delay shipping of medication. By signing below, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing. I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

Signature: _____ _____

Dispense as written **Substitution/brand exchange permitted**

Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

Printed Prescriber Name and Title: _____ FAX: _____

State License Number and State: _____ Phone: _____

Prescriber Office/Clinic Name and Shipping Address (No PO Box): _____

IMPORTANT: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.