



**KISUNLA PREMEDICATION PROTOCOL**  
**Provider Order Addendum (Signature Required)**  
**P: 240-200-4464 F: 240-892-3005**

**PROVIDER / PRACTICE INFORMATION**

Provider name \_\_\_\_\_ Practice / Office \_\_\_\_\_

Office phone \_\_\_\_\_ Office fax \_\_\_\_\_

Provider NPI (optional) \_\_\_\_\_ Email (optional) \_\_\_\_\_

**POLICY REQUIREMENT**

Premedications are mandatory unless a documented contraindication exists and an alternative plan is ordered by the prescribing provider. By signing below, you authorize Active Infusions to apply the Kisunla protocol premedications to your Kisunla infusion orders for your patients per the attached protocol.

**PROVIDER AUTHORIZATION / REQUIRED ALTERNATIVE PLAN**

- A) **AUTHORIZE** protocol premedications for Kisunla infusions for my patients per attached protocol.  
Active Infusions may add the protocol pre-medications to my Kisunla orders without rewritten orders each visit.
- B) **CONTRAINDICATION** protocol premedications not appropriate. I am ordering an alternative plan below.  
Alternative plan must be specific (medication, dose, route, timing) or clearly state 'no premedication' with rationale.

**Exceptions**

If a patient has a contraindication to any required premedication, the prescribing provider must document an alternative plan in the medical record prior to infusion. Nursing staff may not proceed without documented provider direction.

**Alternative Plan / Contraindication Documentation (required if selecting option B)**

**PROVIDER SIGNATURE**

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

# ACTIVE infusions

## **Mandatory Premedication Protocol for Kisunla Infusions**

Effective Date: February 17, 2026

Review Date: 2/18/2026

Approved By: [Signature]

### **Purpose**

To reduce the incidence and severity of infusion-related reactions in patients receiving Kisunla by implementing a standardized, mandatory premedication protocol.

### **Policy Statement**

Due to an observed increase in infusion-related reactions, all patients receiving Kisunla infusions at this infusion center are required to receive the specified premedications prior to each infusion. Premedications are mandatory unless a documented contraindication exists and an alternative plan is ordered by the prescribing provider.

All patients must receive the following prior to every Kisunla infusion:

1. **Acetaminophen (Tylenol)**
  - o 650 mg or 1000 mg PO
  - o Administer 30–60 minutes prior to infusion start
2. **Diphenhydramine (Benadryl)**
  - o 25 mg PO or IV
  - o Administer 15–30 minutes prior to infusion start
3. **Methylprednisolone (Solu-Medrol)**
  - o 125 mg IV
  - o Administer 15–30 minutes prior to infusion start

## **Procedure**

### **Pre-Infusion**

- Verify provider order for Kisunla and required premedications.
- Confirm patient identity using two identifiers.
- Review allergy history, prior infusion reactions, and contraindications.
- Obtain and document baseline vital signs.

### **Premedication Administration**

- Administer all required premedications within the designated timeframes.
- Ensure completion of premedications before initiating infusion.
- Document medication name, dose, route, time administered, and patient tolerance in the medical record.

### **Infusion Initiation**

- Confirm all premedications were administered appropriately.
- Reassess patient prior to infusion start.
- Initiate Kisunla per established infusion protocol.
- Monitor patient per standard infusion monitoring guidelines.

### **Exceptions**

If a patient has a contraindication to any required premedication, the prescribing provider must document an alternative plan in the medical record prior to infusion. Nursing staff may not proceed without documented provider direction.

### **Compliance**

Adherence to this policy is required for all nursing staff administering Kisunla infusions. Deviations must be documented and reported to clinical leadership.

# ACTIVE INFUSIONS | Patient Demographics Request

## Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email [kendrick@activeinfusions.com](mailto:kendrick@activeinfusions.com). Thank you!

## PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

### Patient Name

*Last, First MI*

### Date of Birth

*MM / DD / YYYY*

### Primary Phone Number

*Best phone number*

### Alternate Phone Number

*Alternate number*

### Email Address

*Patient email address*

### Patient's Preferred Method of Contact:

Phone Call  Text Message  Email  No Preference

## EMERGENCY CONTACT

**Required for ALL patients receiving therapy for Alzheimer's Disease**

### Emergency Contact Name

*Full name*

### Relationship to Patient

*e.g. Spouse, Child, Friend*

### Emergency Contact Phone

*Phone number*

### Emergency Contact Email

*Email (if available)*

## PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

### Is the patient the Subscriber / Policy Holder?

Yes  No

### Subscriber / Policy Holder Name

*Full name*

### Relationship to Patient

*e.g. Self, Spouse, Parent*

### Subscriber Date of Birth

*MM / DD / YYYY*

### Subscriber Member ID

*Member ID*

### Insurance Company

*Insurance name*

### Group Number

*Group number*

## COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

### Program Name

*Program name*

### Program ID Number

*ID number on card*

## NOTES / ADDITIONAL INFORMATION