MRN:_________________________

Palmetto Infusion Services

Standard Plan of Treatment for Pamidronate

(Re)Certification Period From_____________________to________________________

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name ______________________________________ Weight: ______________

Allergies:____ Height:_______________

Primary Diagnosis_____________________Secondary Diagnosis: ____________________

ORDERS:

Obtain weight each visit. Vital Signs every 30 minutes beginning with start of infusion, for the first hour, then every1hr until infusion is complete.
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.
Pump, tubing, and supplies needed to complete prescribed therapy.
If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Drug:

□ Pamidronate: ____ Mg in ____ ml 0.9% Normal Saline over ___ hours via pump, Every____Wks

□ Other: ____
.
Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature: ________________________/ ________________________Date: _________
(Dispense as written) (Substitution permitted)

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:
TOLL FREE FAX (866) 872-8920