MRN:___________________________

Palmetto Infusion Services

Standard Plan of Treatment for Avonex

(Re)Certification Period From______________________to___________________________
.

Patient Name____ **Weight:**______________

Allergies:____ **Height:**______________

Primary Diagnosis:_________________________Secondary diagnosis________________________

Orders:

Obtain weight each month (as patient tolerates). Monitor pre-injection vital signs, every visit
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Supplies needed to administer prescribed drug therapy.
If Adverse Drug Reaction, Implement the Standing Adverse Reaction Protocol.

Drug:

☐ Avonex 30 mcg IM Every week

Pharmacist to perform clinical drug monitoring

(No Stamped Signature Please)

Physician Signature: _______________________/________________________Date:______________
(Dispense as written) (Substitution permitted)

Please fax Demographics and Insurance Information to:
TOLL FREE FAX (866) 872-8920