STANDARD ALBUMIN PLAN OF TREATMENT

(Re)Certification Period from ________________ to ________________

Note: We may require MD office notes and/or 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 _______________________________ HT: _____ WT: _____ Allergies: __________________

Diagnosis:
☐ Primary: _________________________________
☐ Secondary: ______________________________

Premedication:
☐ None    or    ☐ 30 minutes prior to infusion with 650 mg Acetaminophen PO and one of the following oral antihistamines:
☐ Diphenhydramine 50 mg    ☐ Fexofenadine 60 mg    ☐ Fexofenadine 180 mg    ☐ Cetirizine 10 mg    ☐ Loratadine 10 mg

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

Dose:
☐ Albumin _____ gm of _____% in _____ ml   ☐ NS or ☐ D5W

Infuse at ______ ml/minute
Monitor patient for 1 hour post infusion

Frequency:
☐ Orders to be completed ________________________________

Other:
Pharmacist to perform clinical drug monitoring

(no stamped signatures please)

Physician’s Signature: ___________________________ Date: _______

(Dispense as written) (Substitution permitted)

Print Physician Name: ________________________________

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920