MRN:____________________

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:____________________

Standard Plan of Treatment for Albumin

(Re) Certification Period From________________________**to** ________________________

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. Patient Name: ____Height (inches): _____Weight (lbs):_____

2. Allergies:____

3. Diagnosis: ☐ Primary ICD**-10 Code:** ________**Diagnosis description:** ____________________________

☐ **Other ICD-10 Code:** ________**Diagnosis description:**____

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4. Pre-medications: ☐ None ***OR Administered 30 minutes prior to infusion as selected:***

a) Acetaminophen: ☐ 650mgs PO ☐ 500mgs PO ☐ 325mgs PO	b) Diphenhydramine: ☐ 25 mgs PO, ☐ 50mgs PO, ☐ 25 mgs IVP, ☐ 50mgs IVP or c) Alternate oral antihistamine to diphenhydramine: ☐ Cetirizine 10 mg, ☐ Loratadine 10 mg, Fexofenadine ☐ 60mgs or ☐ 180mgs

Pre-medicate with other: ____

Orders: Obtain weight each visit. Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22-micron filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. **Extended one (1) hour post infusion monitoring after each treatment as clinically indicated. *If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.***

4. Drug: Albumin 25%

5. Dose: ______________ to infuse over ___________ minutes in Sodium Chloride 0.9% as per protocol.

6. Frequency: ____

Special Orders: ____

Lab Orders: ____

7. Physician's Signature: __________________________/ _______________________Date: _______________

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: ____NPI: __________________

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 3/6/18

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Phone: 1-800-809-1265 Fax: 1-866-872-8920

MRN:______________________

DOB:______________________

Guidelines for Prescribing Albumin

(Required documentation with all initial referrals)

Patient Name: ____ **Referral Date:**____________________

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

___ Other as requested: ____
____
____
____
____

** Warnings/Precautions: • ALBUMIN (HUMAN) 25% SOLUTION, USP should not be given to patients at special risk of developing circulatory overload (i.e., those with a history of congestive cardiac failure, renal insufficiency or stabilized chronic anemia). WARNINGS AND PRECAUTIONS General ALBUMIN (HUMAN) 25% SOLUTION, USP is made from human plasma. Albumin is a derivative of human blood. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases. The physician should discuss the risks and benefits of this product with the patient, before prescribing or administering to the patient. **Adverse Drug Reaction Overview:** Adverse reactions to albumin are rare. Such reactions may be allergic in nature or due to high plasma protein levels from excessive albumin administration. Allergic manifestations include urticaria, chills, fever, and changes in respiration, pulse and blood pressure. The possibility of an anaphylactic reaction occurring in association with albumin is considered extremely rare. In the case of an anaphylactic reaction, discontinue infusion and treat appropriately. See full prescribing information

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 3/6/18

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