MRN:____________________

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

DOB:____________________

Standard Plan of Treatment for Anti-infective/Antibiotic

(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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Orders: Obtain weight each visit. **Vital signs for dosing within the Ambulatory Infusion Clinic at baseline, every 30 minutes beginning with start of infusion, at completion, 30 minutes after FIRST Infusion, and then may discharge when infusion is complete.** 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 **or D5W flush** as per recommended per product information 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, filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES. For home infusion patients: FIRST dosing in Ambulatory Clinic if required.***

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4. Drug: ____

5. Dose: _________________ to infuse over ___________ minutes in ______ ml of Sodium Chloride Or D5W per protocol.

6. Frequency: ____

Other 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 10/11/17

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

MRN:______________________

DOB:______________________

Guidelines for Prescribing Anti-infective/Antibiotic

(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: ____
____
____

Pre-Screening:

___ CBC with Diff, CMP, or cultures results (as available)
___ Clinical lab monitoring may be required if suggested as per specific drug product 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 10/11/17

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