



MRN: _____

Phone: 800-809-1265

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 every 1hr 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)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

866-872-8920