Palmetto Infusion Services
COMPLIANCE

Phone: 800-809-1265

MRN:_____
DOB:_____

Standard Plan of Treatment for Enbrel

(Re)Certification Period From_____to_____

Patient Name_____ **Weight:**_____

Allergies:_____ **Height:**_____

DIAGNOSIS: **Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

- ☐ **ICD-10 M05._____** Rheumatoid Arthritis with Rheumatoid factor
- ☐ **ICD-10 M06._____** Rheumatoid Arthritis without Rheumatoid factor
- ☐ **ICD 10 L40.5___** Psoriatic Arthropathy
- ☐ **ICD 10 M45.__** Ankylosing Spondylitis

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:

☐ Enbrel _____ mg Sub Q Every _____ week(s)

Pharmacist to perform clinical drug monitoring

(No Stamped Signature Please)

Physician Signature: _____/_____Date:_____
(Dispense as written) (Substitution permitted)

Print Physician Name:_____

Please fax Demographics and Insurance Information to:

866-872-8920

Revised 10/22/15

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