





MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

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

**Guidelines for Prescribing**  
(Required documentation with all initial referrals)

Patient Name: \_\_\_\_\_ Referral Date: \_\_\_\_\_

\_\_\_ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-9)  
(Infusion order forms & Standard Adverse Reactions orders are available at [www.palmettoinfusion.com](http://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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.**