

**Standard Plan of Treatment for Intralipids**

(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: Baseline and every 30 minutes until infusion 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.**

Infuse 4 ML 20% Intralipid Solution in 250 ML Normal Saline over 45 minutes to 1 hour

Additives: \_\_\_\_\_

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**