



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

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

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

### Standard Plan of Treatment for Levothyroxine

(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. 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 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. **Extended 15-minute post treatment monitoring after each treatment dose. If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.**

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4. Drug: Levothyroxine Sodium \_\_\_\_\_ mcg IVP administered \_\_\_\_\_ x per week Refills: \_\_\_\_\_

5. Labs:  TSH and Free T4 level \_\_\_\_\_  
(specify frequency of clinical monitoring)

Special Orders: \_\_\_\_\_

6. Physician's Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: \_\_\_\_\_ NPI: \_\_\_\_\_

**7. Fax updated supporting clinical MD notes with each order renewal or change in orders**  
Infusion order forms available at [www.palmettoinfusion.com](http://www.palmettoinfusion.com)



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

Patient Name: \_\_\_\_\_

Referral Date: \_\_\_\_\_

- \_\_\_ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-7)  
(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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pre-Screening:**

\_\_\_ TSH and Free T4 level within last 30 days

**\*\* Warnings/Precautions:** Consider the patient's age, general physical condition, and cardiac risk factors when selecting initial and maintenance dosages. An initial intravenous loading dose of Levothyroxine Sodium for Injection between 300 to 500 mcg followed by once daily intravenous maintenance doses between 50 and 100 mcg should be administered, as clinically indicated, until the patient can tolerate oral therapy. Excessive bolus doses of Levothyroxine Sodium for Injection (> 500 mcg) are associated with cardiac complications, particularly in the elderly and in patients with an underlying cardiac condition. Initiate therapy with doses at the lower end of the recommended range. Close observation of the patient following the administration of Levothyroxine Sodium for Injection is advised and clinical monitoring suggested. Levothyroxine Sodium for Injection therapy for patients with previously undiagnosed endocrine disorders, including adrenal insufficiency, hypopituitarism, and diabetes insipidus, may worsen symptoms of these endocrinopathies. See full prescribing 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.**