



MRN: _____
 DOB: _____

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

Standard Plan of Treatment for Magnesium

(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: E83.42 Hypomagnesium
 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 as per recommended per product information 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, 0.22-micron filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.***

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4. Drug: Magnesium Sulfate _____ gm in 250-500 ml of Sodium Chloride 0.9% infused per protocol
 (Magnesium Sulfate is infused 2gms per hour per protocol unless otherwise specified or clinically indicated)

5. Frequency: Every _____ week(s) or _____

6. Labs: Magnesium level prior to each infusion or _____
 (specify frequency of clinical monitoring)

Special Orders: _____

7. Physician's Signature: _____ / _____ Date: _____
 No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders
 Infusion order forms available at www.palmettoinfusion.com



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

Patient Name: _____

Referral Date: _____

___ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-8)
(Infusion order forms & Standard Adverse Reactions orders are available at 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:

___ Magnesium Level within last 30 days

**** Warnings/Precautions:** **Contraindications:** Parenteral administration of the drug is contraindicated in patients with heart block or myocardial damage. **Fetal harm:** Continuous administration of magnesium sulfate beyond 5 to 7 days to pregnant women can lead to hypocalcemia and bone abnormalities in the developing fetus. **Administer with caution:** if flushing and sweating occur, if used in conjunction with barbiturates, narcotics or other hypnotics as the dosage should be adjusted with caution because of additive CNS depressant effects of magnesium. **Renal Impairment:** magnesium is removed from the body solely by the kidneys, the drug should be used with caution in patients with renal impairment. **Clinical Monitoring:** serum magnesium levels and the patient's clinical status is essential to avoid the consequences of over dosage in toxemia. Clinical indications of a safe dosage regimen include the presence of the 4-patellar reflex (knee jerk) and absence of respiratory depression (approximately 16 breaths or 5 more/min). 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.