

**STANDARD ALBUMIN PLAN OF TREATMENT**

(Re)Certification Period from \_\_\_\_\_ to \_\_\_\_\_

**Note:** We may require MD office notes and/or 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 \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Diagnosis:**  Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_**Premedication:**  None *or*  30 minutes prior to infusion with 650 mg Acetaminophen PO  
*and* one of the following *oral* antihistamines: Diphenhydramine 50 mg  Fexofenadine 60 mg  Fexofenadine 180 mg  Cetirizine 10 mg  Loratadine 10 mg**Orders:**

Obtain weight each visit. Vital Signs: baseline then every 30 minutes until infusion complete and 1 hour post.

Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Pump, tubing, and supplies needed to complete prescribed therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 5-10 ml pre- infusion, after primary drug has infused, infuse Normal Saline 0.9% 20-50 ml to flush tubing/line followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.

**If adverse drug reaction, Implement the Standing Adverse Reaction protocol.****Dose:** Albumin \_\_\_\_\_ gm of \_\_\_\_\_% in \_\_\_\_\_ ml  NS *or*  D5W

Infuse at \_\_\_\_\_ ml/minute

Monitor patient for 1 hour post infusion

**Frequency:** Orders to be completed \_\_\_\_\_**Other:**

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**