Palmetto Infusion Services

MRN:______________________

Phone: 800-809-1265

Standard Plan of Treatment for Enbrel

(Re)Certification Period From_____________________to_________________________

.

Patient Name____ Weight:____________

Allergies:____ Height:____________

Primary Diagnosis:______________________Secondary diagnosis____________________

Orders:

Obtain weight each month (as patient tolerates). Monitor pre-injection vital signs, every visit
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Supplies needed to administer prescribed drug therapy.
If Adverse Drug Reaction, Implement the Standing Adverse Reaction Protocol.

Drug:

□ Enbrel ______ mg Sub Q Every ______ week(s)

Pharmacist to perform clinical drug monitoring

(No Stamped Signature Please)

Physician Signature: ____________________/_____________________Date:_____________
(Dispense as written) (Substitution permitted)

Print Physician Name:____

Please fax Demographics and Insurance Information to:

866-872-8920

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