



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

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

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

### Standard Plan of Treatment for Zemdri® (plazomicin)

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: N39.0 Diagnosis description: Urinary Tract Infection, site not specified  N10 Acute Pyelonephritis

Other ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

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***If adverse drug reaction should occur, utilize the ADVERSE DRUG REACTION GUIDELINES.***

4. Drug Dose: Zemdri \_\_\_\_\_ mg IV

5. Frequency:  Every 24 hours  Every 48 hours

6. Duration: Administer for \_\_\_\_\_ Days

7. Lab Orders: Initial creatinine clearance required.

Additional Lab 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](http://www.palmettoinfusion.com)



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**Guidelines for Prescribing Zemdri® (plazomicin)**  
(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](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:**

- \_\_\_ CBC with Diff, CMP, or cultures results (as available)
- \_\_\_ Clinical lab monitoring may be required if suggested as per specific drug product 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.**