MRN:_____

DOB:_____

Standard Plan of Treatment for Magnesium

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 Hypomagnesemia
Other ICD-10 Code:_____ Diagnosis description: _____

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.***

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: _____

MRN:_____

DOB:_____

Guidelines for Prescribing Magnesium

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ 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

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.