Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Aredia® (pamidronate disodium) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:							
Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)	
☐	_____ - Other:
☐	_____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	BMP results required within last 30 days		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

NOTE: Single maximum dose of pamidronate disodium should not exceed 90mg. Infusion rates vary by indication and renal function. Longer infusion times may reduce risk of renal toxicity, especially in patients with preexisting renal insufficiency. Evaluation of calcium and vitamin D supplementation should be reviewed prior to start of therapy if indicated. Treatment will not be administered if the serum calcium is subtherapeutic.

MEDICATION:

☑ Pamidronate disodium in NS given IV over 2 to 4 hours

DOSE:

☑ _____mg in _____ml NS

FREQUENCY:

- ◯ One time dose
- ◯ Every _____ weeks
- ◯ Every _____ months
- ◯ Other:_____

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Creatinine clearance </=30 ml/min or Serum Creatinine > 3 mg/dL: dose will be held unless written clearance is provided by MD
Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

SPECIAL ORDERS:

◯ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:	
PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023