Palmetto INFUSION®

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

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

# Levothyroxine 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 INJECTION DATE: |
| 3 | Full medication list | | NEXT INJECTION DATE: |
| 4 | Tried and failed therapies | | **IF ORDER CHANGE:** |
| 5 | TSH and Free T4 within 30 days | | ☐ **Continue current order until insurance approved** |
| 6 | | | |

## MEDICATION ORDERS:

**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.**

### MEDICATION:

☑ Levothyroxine Sodium

### DOSE/FREQUENCY:

☐ Administer _____mcg via slow IV push _____ x per week

☐ Other:_____

### DURATION:

☐ For _____ weeks ☐ For _____ Months

### SPECIAL ORDERS:

☐ _____

☑ Refills sufficient for duration unless otherwise noted here:

## LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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 | |