Palmetto INFUSION®

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

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

Zemdri® (plazomicin) 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	☐ NKDA

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

☐	N39.0 - Urinary Tract Infection, site not specified	☐	N10 - Acute Pyelonephritis
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS AMINISTRATION: 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	Include Labs and tests results to supportdiagnosis		☐ **Continue current order until insurance approved**
6	BMP within 30 days		

☐ **Pharmacist to dose:** **Pharmacist will dose according to FDA labeling**. This requires the provider to send a BMP within last 30 days

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:

☑ Zemdri® diluted in 50ml NS

DURATION:

☐ Administer for _____ Days

Maximum reccomended duration 14 days

DOSE:

☐ 15mg/kg
☐ 10mg/kg
☐ Other:_____

SPECIAL/LAB ORDERS:

☐ _____
_____

FREQUENCY:

☐ One time dose
☐ Every 24 hours
☐ Every 48 hours
☐ Other:_____

*****INITIAL CREATININCE CLEARANCE REQUIRED*****

☑ Refills:

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	