Palmetto INFUSION

Phone: 1-800-809-1265 ext 105 Fax: 1-888-417-3658

MRN:_____

DOB:_____

Standard Plan of Treatment for Anti-infective/Antibiotic

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:**_____**Diagnosis description:** _____

☐ **Other ICD-10 Code:**_____**Diagnosis description:**_____

4. Orders: Heparin and saline or D5W flushes as needed to maintain line (A4221). Related items and/or supplies needed to administer medication and complete prescribed therapy (A4222). Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction should occur, utilize the ADVERSE DRUG REACTION GUIDELINES. For home infusion patients: FIRST dosing in Ambulatory Clinic if required.***

5.Drug: _____

6. Dose:_____to infuse over_____minutes in_____ml of Sodium Chloride or D5W per protocol.

7. Frequency: _____

Dispense: _____ dose/doses **Refills**: _____

Other Orders: _____

8. Physician's Signature:_____/_____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____NPI: _____

9. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 12/9/2021

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MRN:_____

DOB:_____

Guidelines for Prescribing Anti-infective/Antibiotic

(Required documentation with all initial referrals)

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

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-9)*
(Infusion order forms & Standard Adverse Reactions orders are available at 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 1-888-417-3658 or call 1-800-809-1265 for assistance.

Revised 12/9/2021