



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

Kimyrsa™ (oritavacin) Standard Plan of Treatment

Rev. 4.29.25

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/>	<input type="checkbox"/> Order Renewal
Patient preferred clinic:			

PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		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)

_____ - 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5		THERAPY:	
6			
			Continue current order until insurance approved

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:

Kimyrsa™ (oritavacin) in 250ml of NS given IV to infuse over 1 hour

DOSE/FREQUENCY:

1200mg x 1 single dose.

Other: _____

Observe patient for 30 minutes after infusion is complete.

SPECIAL/LAB ORDERS:

Refills: _____

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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PRESCRIBER INFORMATION:

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

PRESCRIBER SIGNATURE: (No stamp signatures) DATE

_____	_____	DATE
Dispense as written/Brand medically necessary	Substitution permitted	