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

Rev. 4.29.25

# Magnesium Standard Plan of Treatment

## 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 | ☐ NDKA |
|---|---|---|---|---|---|

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

| | |
|---|---|
| ☐ | E83.42 - Hypomagnesium |
| ☐ | ________ - Other: |

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | Magnesium level within the last 30 days |
| 6 | |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| IF NO: | IF YES: |
|---|---|
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| | NEXT INFUSION DATE: |
| | **IF ORDER CHANGE:** |
| | ☐ **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.**

## DOSE/FREQUENCY:

☑ Magnesium Sulfate ______ gm in 250 -500 ml of NS infused via IV per protocol

**Magnesium Sulfate is infused 2gms per hour per protocol unless otherwise specified or clinically indicated**

## FREQUENCY:

☐ One time dose
☐ Every _____ week(s)
☐ Other:______________________________________________

## DURATION:

☐ ________ Weeks ☐ _______ Months

## SPECIAL/LAB ORDERS: (Same day lab monitoring not available in ambulatory infusion clinics)

☐ ______________________________________________

**Provider to be responsible for magnesium lab monitoring.**
**(Same day lab monitoring not available in ambulatory infusion clinics)**

☑ Refills sufficient for duration unless otherwise noted here:

| LINE USE/CARE ORDERS: | ADVERSE REACTION & ANAPHYLAXIS ORDERS: |
|---|---|
| ☑ Start PIV/Access CVC<br>☑ Flush device per facility standard flushing procedure<br>☑ 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. |

## 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 | |

# 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com