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 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 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 | | |

## 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.

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

**MEDICATION:**

☑ Zemdri® diluted in 50ml NS IV over 30 minutes

**DOSE:**

- ☐ 15mg/kg
- ☐ 10mg/kg
- ☐ Other:_____

**FREQUENCY:**

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

**DURATION:**

☐ Administer for _____ Days

**Maximum reccomended duration 14 days**

**SPECIAL/LAB ORDERS:**

☐ _____

_____

*****INITIAL CREATININE CLEARANCE REQUIRED*****

☑ Refills:

## LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

## 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 | |