



INFUSION ORDERS- PAMIDRONATE DISODIUM

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral
 Dose or Frequency Change
 Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Hypercalcemia of Malignancy	ICD10 Code: E83.2
<input type="checkbox"/> Multiple Myeloma with osteolytic bone lesions	ICD10 Code: E83.2
<input type="checkbox"/> Paget's Disease	ICD10 Code: M88.89
<input type="checkbox"/> Diagnosis: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Recent serum calcium level and serum creatinine	

MEDICATION ORDERS

Dosing	Please include frequency in blank space provided: <input type="checkbox"/> Pamidronate 30mg IV every _____ <input type="checkbox"/> Pamidronate 60mg IV every _____ <input type="checkbox"/> Pamidronate 90mg IV every _____ <input type="checkbox"/> Other: Pamidronate _____ mg IV every _____ Please note: ALL doses will be administered over a <i>minimum of 2 hours</i>
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Refills: X 6 months X 1 year _____ doses

PRESCRIBER INFORMATION

Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.