MIC | METRO INFUSION CENTER

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	
☐ Hypercalcemia of Malignancy	ICD10 Code: E83.2
☐ Multiple Myeloma with osteolytic bone lesions	ICD10 Code: E83.2
☐ Paget's Disease	ICD10 Code: M88.89
☐ Diagnosis: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Recent serum calcium level and serum creatinine	

MEDICATION ORDERS	
Dosing	Please include frequency in blank space provided: ☐ Pamidronate 30mg IV every _____ ☐ Pamidronate 60mg IV every _____ ☐ Pamidronate 90mg IV every _____ ☐ Other: Pamidronate _____mg IV every _____ Please note: ALL doses will be administered over a *minimum of 2 hours*
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

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

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164