

<b>ANAPHYLAXIS PRESCRIBER ORDER FORM</b>			
Patient Name:		Date of Birth:	
Gender:		Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	
Address:			
Anaphylaxis Kit Components			
PATIENT WEIGHT	MEDICATION	DOSAGE	ADMINISTRATION INFORMATION
<b>Adults &amp; Pediatrics &gt; 30 kg</b>	Epinephrine 1 mL ampule/vial (1 mg/mL) #2 <b>or</b> *Epinephrine 0.3 mg auto-injector 2-pack kit #1	0.3 mg	IM or SUBQ x 1 dose & may repeat x 1 in 5 to 15 min PRN
	0.9% Sodium Chloride 500 mL bag #1	500 mL	KVO rate PRN anaphylaxis
	Diphenhydramine 1 mL (50 mg/mL) vial #1	25 mg	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
<b>Pediatrics 15 to 30 kg</b>	Epinephrine 1 mL ampule/vial (1 mg/mL) #2 <b>or</b> *Epinephrine 0.15 mg auto-injector 2-pack kit #1	0.15 mg	IM or SUBQ x 1 dose & may repeat x 1 in 5 to 15 min PRN
	0.9% Sodium Chloride 250 mL bag #1	250 mL	KVO rate PRN anaphylaxis
	Diphenhydramine 1 mL (50 mg/mL) vial #1	1.25 mg/kg (25 mg max per dose)	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
<b>Pediatrics &lt; 15 kg</b>	Epinephrine 1 mL ampule/vial (1 mg/mL) #2	0.01 mg/kg	IM or SUBQ x 1 dose & repeat x 1 in 5 to 15 min PRN
	0.9% Sodium Chloride 250 mL bag #1	250 mL	KVO rate PRN anaphylaxis
	Diphenhydramine 1 mL (50 mg/mL) vial #1	1.25 mg/kg	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
Dispense supplies necessary to administer aforementioned medications, including syringes and needles. *For subcutaneous immune globulin patients, only epinephrine auto-injector 2-pack kits will be dispensed.			
Anaphylaxis Management for All IV Medication Administration, Including IV Immune Globulin			
<i>If nurse is present in the home, for <b>SEVERE</b> reactions including angioedema, wheezing, difficulty in breathing, or swelling of eye lids, lips, or throat.</i> <ol style="list-style-type: none"> <li>1. <b>Stop</b> the infusion of the medication immediately. Completely remove the source of the infusate while maintaining venous access.</li> <li>2. Contact or have caregiver call 911.</li> <li>3. Administer epinephrine as above and may repeat dose if necessary.</li> <li>4. Administer <b>injectable</b> diphenhydramine (Benadryl®) as above.</li> <li>5. Monitor and document patient's vital signs, including mental status. If hypotensive, place the patient in supine position with lower extremities elevated or in Trendelenburg position. If breathing difficulty, tilt the patient's head or thrust jaw to relieve airway obstruction.</li> <li>6. Maintain IV line with normal saline (sodium chloride 0.9%) as above to keep line open until the arrival of a paramedic or ambulance.</li> <li>7. Contact the prescriber and Option Care Health Director of Nursing or pharmacist.</li> <li>8. If cardiopulmonary arrest occurs, begin CPR.</li> <li>9. Monitor and document vital signs every 2 minutes until stable, then every 15 minutes as needed.</li> <li>10. Remain with patient until paramedics arrive.</li> </ol>			
<b>Subcutaneous Immune Globulin Anaphylaxis – For <b>SEVERE</b> reactions such as wheezing, difficulty in breathing, or swelling of eye lids, lips, or throat.</b> <ol style="list-style-type: none"> <li>1. <b>Stop</b> the infusion of the medication immediately and remove the needles from the skin.</li> <li>2. Call 911.</li> <li>3. Administer epinephrine for one dose as above, repeat dose if necessary.</li> <li>4. Notify prescriber and Option Care Health Director of Nursing or pharmacist.</li> </ol>			
When appropriate, nurse shall instruct patient/caregiver about the signs/symptoms of allergic, anaphylactic, and adverse reactions along with the proper use of kit medications. This physician order shall be recognized for the patient's period of treatment and/or up to one year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.			
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>			
Prescriber Signature:		Date:	
Prescriber Information			
Prescriber Name:		NPI:	
Fax completed form, insurance information, and clinical documentation to:			
<small>CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. <b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small>			