



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **888-688-3593**.

Sincerely,  
Option Care Health

Bleeding Disorder Prescriber Order Form				
Patient Name:		Date of Birth:		Gender:
Address:				
Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Severity: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 3				
IV access device:			Nursing required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional information:				
Factor Product Prescription				
Factor Product:		Dosing Regimen:		
Select One: <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Episodic <input type="checkbox"/> Peri-operative				
Additional dosing instructions:				
Refill as directed <input type="checkbox"/> x6 months <input type="checkbox"/> x12 months <input type="checkbox"/> _____ times				
<b>Actual factor replacement product dose may be within (+/-10%) than the target dose specified.</b>				
Ancillary Orders				
IV Flush Orders				
<input type="checkbox"/> Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.				
<input type="checkbox"/> For Maintenance ( <i>select one</i> ): <input type="checkbox"/> 0.9% Sodium Chloride 2 to 3 mL every 12 hr <b>or</b> <input type="checkbox"/> Heparin (10 unit/mL) 1 to 3 mL every 24 hr.				
<b>If infusing via Peripheral IV, skilled nurse to insert.</b>				
<input type="checkbox"/> Peripheral-Midline: 0.9% Sodium Chloride NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.				
Heparin (10 unit/mL) 3 mL post-use.				
<input type="checkbox"/> For Maintenance ( <i>select one</i> ): Heparin <input type="checkbox"/> (10 unit/mL) 3 mL every 12 hr <b>or</b> <input type="checkbox"/> (100 unit/mL) 3 mL every 24 hr.				
<b>If infusing via Peripheral IV, skilled nurse to insert.</b>				
<input type="checkbox"/> PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.				
(Select one): Heparin <input type="checkbox"/> (10 unit/mL) 5 mL <b>or</b> <input type="checkbox"/> (100 unit/mL) post-use.				
<input type="checkbox"/> For Maintenance ( <i>select one</i> ): Heparin <input type="checkbox"/> (10 unit/mL) 5 mL <b>or</b> <input type="checkbox"/> (100 unit/mL) 3 mL every 24 hr.				
<input type="checkbox"/> Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.				
Heparin (100 unit/mL) 3 to 5 mL post-use.				
For Maintenance, Heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed, or weekly to monthly if not accessed.				
<b>Nurse to access implanted port.</b>				
<input type="checkbox"/> Valved Catheters: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, 0.9% Sodium Chloride 5 to 10 mL at least weekly.				
<input type="checkbox"/> Apply 30 – 60 minutes prior to access: <input type="checkbox"/> EMLA cream, 30g tube <input type="checkbox"/> LMX cream, 30g tube				
<b>Skilled nurse to administer doses intravenously where applicable. Skilled nurse to assess and teach self-administration of SUBQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.</b>				
<b>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.</b>				
<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:		Phone:		Fax:
Address:		NPI:		
City, State:		Zip:	Office Contact:	
<p><b>CONFIDENTIAL HEALTH INFORMATION:</b> 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.</p>				