

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				
Actual factor replacement product dose may be within (+/-10%) than the target dose specified.				
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 or <input type="checkbox"/> Heparin (10 unit/mL) 1 to 3 mL every 24 hr.				
If infusing via Peripheral IV, skilled nurse to insert.				
<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 or <input type="checkbox"/> (100 unit/mL) 3 mL every 24 hr.				
If infusing via Peripheral IV, skilled nurse to insert.				
<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 or <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 or <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.				
Nurse to access implanted port.				
<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				
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.				
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:		Phone:		Fax:
Address:		NPI:		
City, State:		Zip:	Office Contact:	
Fax completed form, insurance information, and clinical documentation to: 888-688-3593				
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