



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 **713-983-4647**.

Sincerely,
Option Care Health

C1 ESTERASE INHIBITOR [HUMAN] (BERINERT®) PRESCRIBER ORDER FORM

Patient Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone: _____

Height: _____

 inches cm

Weight: _____

 lbs. kg**Clinical Information**

Primary Diagnosis Description: Defects in the complement system (hereditary angioedema)

ICD-10 Code: D84.1

C1 Esterase Inhibitor [Human] (Berinert®) Prescription**C1 Esterase Inhibitor [Human] (Berinert®) 500 unit vial refill as directed x 1 year**

Infuse _____ units by slow IV injection at a rate of 4 mL/min as needed for acute HAE attack.

Round dose to the nearest whole vial to avoid waste.

Dispense _____ doses.

Keep _____ doses on-hand at all times.

Ancillary Orders**Anaphylaxis Kit**

Does this patient require an anaphylaxis kit?

 Yes, with 1st dose Yes, with all doses**Pre-Medication Orders** Other: _____**IV Flush Orders** Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. 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.

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. 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 certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____

Phone: _____

Fax: _____

Address: _____

NPI: _____

City, State: _____

Zip: _____

Office Contact: _____

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. **IMPORTANT WARNING:** 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.