



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

Gaucher's Disease - Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:																		
From:	X	Fax:	# Pages, Incl. Cover:																		
Patient Name:		Patient Phone:	DOB:																		
Address:		City:	State:																		
Primary Diagnosis																					
<input type="checkbox"/> E75.21 - Fabry (Anderson) Disease <input type="checkbox"/> E75.22 - Gaucher Disease <input type="checkbox"/> E75.249 - Niemann-Pick Disease, unspecified		<input type="checkbox"/> E77.0 - Defects in Post-Translational Modification of Lysosomal Enzymes <input type="checkbox"/> E77.1 - Defects in Glycoprotein Degradation <input type="checkbox"/> Other (ICD-10 Code and Description): _____																			
In order to service your patient and facilitate insurance authorization, please complete the sections below:																					
1	Ht: _____ <input type="checkbox"/> in <input type="checkbox"/> cm Wt: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Date: _____ <input type="checkbox"/> Attach Patient demographics, Insurance information, History and Physical, Medication list, and recent pertinent lab results		<input type="checkbox"/> Date of first dose: _____ <input type="checkbox"/> Number of doses administered: _____ Preferred site of administration: <input type="checkbox"/> Patients Home <input type="checkbox"/> Option Care Ambulatory Treatment Site																		
2	Prescription: <input type="checkbox"/> Cerezyme (imiglucerase) <input type="checkbox"/> VPRIV (velaglucerase alfa) Dose: 60 units/kg or _____ units/kg IV every _____ week(s). (Dose will be round up to the nearest vial size) <input type="checkbox"/> Decline Infusion Rate: Infuse in 100mls 0.9% NS over 60 minutes or _____ minutes. (Rate may be decreased in the event of an infusion related reaction) Refills x _____																				
3	Supporting Orders: <input type="checkbox"/> Acetaminophen 650 mgs orally 30 minutes before infusion. <input type="checkbox"/> Diphenhydramine 25 mgs orally 30 minutes before infusion. <input type="checkbox"/> Methylprednisolone 40 mgs IVP 20 minutes before infusion. <input type="checkbox"/> Other: _____ <ul style="list-style-type: none"> Anaphylaxis: Stop infusion, Call EMS, Give epinephrine 0.3 mgs IM, diphenhydramine 25 - 50 mg oral/injectable, 0.9% Sodium Chloride 250 mls per hour bag as needed per symptoms. Call prescriber. If applicable, flush intravenous access device per instructions in chart. → When appropriate: Provide infusion pump(s) and supplies necessary to administer therapy and skilled nurse to administer doses in the home/alternate care setting via vascular access device. Refill ancillary medications x 1 year. *Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request. 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Access Device Flush Protocol</th> <th style="width: 25%;">0.9% Sodium Chloride Flush</th> <th style="width: 50%;">Heparin</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Peripheral</td> <td style="text-align: center;">2 - 3 ml pre/post use</td> <td style="text-align: center;">1 - 3 ml (10 units/ml) post use; maintenance q24hr</td> </tr> <tr> <td style="text-align: center;">Peripheral-Midline</td> <td style="text-align: center;">3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td style="text-align: center;">3 ml (100 units/ml) post use; maintenance q24hr</td> </tr> <tr> <td style="text-align: center;">PICC & Central Tunneled & Non-tunneled</td> <td style="text-align: center;">5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td style="text-align: center;">3 ml (heparin 100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr</td> </tr> <tr> <td style="text-align: center;">Implanted Port</td> <td style="text-align: center;">5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw</td> <td style="text-align: center;">3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly</td> </tr> <tr> <td style="text-align: center;">Valved Catheters: Chest, PICC, Midline</td> <td style="text-align: center;">5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly</td> <td style="text-align: center;">N/A</td> </tr> </tbody> </table>	Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin	Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr	Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (100 units/ml) post use; maintenance q24hr	PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr	Implanted Port	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly	Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A	
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4	Lab and Other Orders:																				
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: _____																			
Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____		Office Contact: _____																			
<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 don't 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.</small>																					

Local Contact Information: _____