



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

General Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:
Patient Name:	Patient Phone:	DOB:	Gender:
Address:	City:	State:	Zip:

Primary Diagnosis

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
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2	Prescription: Medication: _____ Dose: _____ Frequency: _____ Refills x _____
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3	Ancillary Orders: <input type="checkbox"/> Acetaminophen 650 mg orally 30 minutes before infusion <input type="checkbox"/> Diphenhydramine 25 mg orally 30 minutes before infusion. <input type="checkbox"/> Methylprednisolone Na Succ 40 mg 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 MD. 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. 	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 3-5ml 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

4	Lab and Other Orders: _____ _____ _____
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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: _____
Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	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 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.

Local Contact Information: _____