

**General Enzyme Replacement Prescriber Order Form**

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

**Primary Diagnosis**

ICD-10 Code and Description: \_\_\_\_\_

**In order to service your patient and facilitate insurance authorization, please complete the sections below:**

<b>1</b>	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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<b>2</b>	<b>Prescription:</b> Medication: _____ Dose: _____ Frequency: _____ Refills x _____
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<b>3</b>	<b>Ancillary Orders:</b> <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"> <li>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.</li> <li>If applicable, flush intravenous access device per instructions in chart. →</li> <li>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.</li> <li>Refill ancillary medications x 1 year.                      *Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request.</li> </ul>	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

<b>4</b>	<b>Lab and Other Orders:</b> _____ _____ _____
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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.*

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Office Contact: _____

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Local Contact Information: \_\_\_\_\_

**Fax completed form, insurance information, and clinical documentation to: (713) 983-4647**

**Not valid for use for patients residing in Arizona, New York, and Wisconsin.**