HOME INFUSION PHARMACY PRESCRIBER ORDER FORM

Pharmacy Name:	**Address:**	**Phone#:** **Fax#:**
Prescriber/Practice Group/Health System Name:		
Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies:	

Prescription

Please indicate medication, dose, frequency, route, and length of therapy:

Ancillary Orders

IV Flush Orders

Access Device	0.9% NaCl Flush	Heparin
Peripheral IV	☐ 2-3 mL pre/post infusion ☐ 2-3 mL every 12 hours for maintenance	☐ N/A ☐ 1-3 mL heparin (10 units/mL) every 24 hours for maintenance
Peripheral- Midline	☐ 3-5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	☐ 3 mL heparin (10 units/mL) post-use or every 12 hours if not used ☐ 3 mL heparin (10 units/mL) post-use or 3 mL heparin (100 units/mL) every 24 hours for maintenance
PICC & Central Tunneled & Non-tunneled	☐ 5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	☐ 5 ml (heparin 10 units/ml) post use or every 24 hours if not used ☐ 3 ml (heparin 100 units/ml) post use or every 24 hours if not used
Implanted Port	☐ 5 - 10 ml pre/post infusion, 10 - 20 ml pre/ post lab draw	☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used ☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
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

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Fax results to pharmacy at_____ and to prescriber as noted below in the Prescriber information section.

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:**	

