

# 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	<input type="checkbox"/> 2-3 mL pre/post infusion <input type="checkbox"/> 2-3 mL every 12 hours for maintenance	<input type="checkbox"/> N/A <input type="checkbox"/> 1-3 mL heparin (10 units/mL) every 24 hours for maintenance
Peripheral- Midline	<input type="checkbox"/> 3-5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	<input type="checkbox"/> 3 mL heparin (10 units/mL) post-use or every 12 hours if not used <input type="checkbox"/> 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	<input type="checkbox"/> 5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	<input type="checkbox"/> 5 mL (heparin 10 units/ml) post use or every 24 hours if not used <input type="checkbox"/> 3 mL (heparin 100 units/ml) post use or every 24 hours if not used
Implanted Port	<input type="checkbox"/> 5 - 10 ml pre/post infusion, 10 - 20 ml pre/ post lab draw	<input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used <input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
Valved Catheters: Chest, PICC, Midline	<input type="checkbox"/> 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:

**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.