HOME INFUSION PHARMACY PRESCRIBER STANDING ORDER FORM - PEDIATRIC

Pharmacy Name:	**Address:**	**Ph:**

Prescriber/Practice Group/Health System Name:

Address:

Phone:	**City, State:**	**Zip:**

Prescription

☐ **By signing below, I authorize the use of the flush medications and associated directions on my/our patients as applicable to the type of access device being utilized. This order will be valid for 1 year from the date it is signed.**

Utilization of Standing Order

When utilized, please indicate patient's name and date implemented. A scanned copy of this document will be placed in the patient's electronic medical record.

Patient Name: **Gender:** **DOB:** **Date Implemented:**

IV Flush Orders Ancillary Orders

Access Device	0.9% NaCl Flush	Heparin
Peripheral IV or Midline	☐ ≤20kg: 1 mL pre/post infusion, 1-3mL pre/post blood draw ☐ >20 kg: 1-3 mL pre/post infusion, 3-5mL pre/post blood draw ☐ Other:	☐ N/A ☐ < 2kg: 0.5-1mL heparin (1 unit/mL) post infusion or every 6 hours for maintenance ☐ 2-20kg: 1mL heparin (10 units/mL) post infusion or every 12-24 hours for maintenance ☐ >20kg: 1-3mL heparin (10 units/mL) post infusion and 1-3 mL every 12-24 hours for maintenance ☐ Other:
PICC & Central Tunneled & Non-tunneled	☐ ≤20kg: 1 mL pre/post infusion, 1-3 mL pre/post lab draw ☐ >20 kg: 1-3 mL pre/post infusion, 3-5 mL pre/post lab draw ☐ Other:	☐ <2kg: 0.5 mL - 1 mL (heparin 1 units/mL) post use or every 6 hours if not used ☐ 2-20 kg: 1-3 mL heparin (10 units/mL) post infusion or 1-3 mL heparin (10 units/mL) every 12-24 hours for maintenance ☐ >20 kg 1-3 mL heparin (10 units/mL) post infusion or every 12-24 hours for maintenance ☐ Other:
Implanted Port	☐ 1-3 mL pre/post infusion, 3-5mL pre/ post lab draw ☐ Other:	☐ < 2kg: 0.5-1mL heparin (1 unit/mL) post infusion or weekly/minimum monthly for maintenance ☐ 2-20kg: 3-5mL heparin (10 units/mL) post infusion or weekly/minimum monthly for maintenance ☐ >20kg: 3-5 mL heparin (10 units/mL) post infusion or weekly/minimum monthly for maintenance ☐ Other:
Valved Catheters: Chest, PICC, Midline	☐ ≤20kg: 1 mL pre/post infusion, 1-3mL pre/post blood draw ☐ >20 kg 1-3 mL pre/post infusion, 3-5mL pre/post blood draw; maintenance 3 - 5 mL weekly ☐ Other:	N/A

Catheter Occlusion

☐ Cathflo Activase
- ☐ 1 mg (midlines or patients <30 kg)
- ☐ 2 mg

Instill into occluded catheter. Let dwell for 30 minutes before attempting to aspirate. Total dwell time not to exceed 120 minutes.

☐ May repeat x 1 dose.

Anaphylaxis Orders

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with All doses

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

☐ SUBQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 PRN.

The need to utilize the kit and protocol will be based on patient need.

Nursing Orders: Skilled nurse to assess and administer and/or teach caregiver or 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.

Prescriber Signature: **Date:**

Authorizing Prescriber Name:	**Phone:**	**Fax:**

Address:	**NPI:**

City, State:	**Zip:**	**Office Contact:**

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