

HOME INFUSION PHARMACY PRESCRIBER STANDING ORDER FORM - PEDIATRIC

Pharmacy Name:	Address:	Ph:
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Prescriber/Practice Group/Health System Name:

Address:

Phone:	City, State:	Zip:
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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:
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IV Flush Orders Ancillary Orders

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

Catheter Occlusion

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

1 mg (midlines or patients <30 kg) May repeat x 1 dose.
 2 mg

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:
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Authorizing Prescriber Name:	Phone:	Fax:
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Address:	NPI:
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City, State:	Zip:	Office Contact:
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Fax completed form, insurance information, and clinical documentation to:

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.

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