



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to \_\_\_\_\_.

Sincerely,  
Option Care Health

**Hyperemesis Gravidarum Therapy****Patient Information**

Patient Name:		SSN:	Age:
Address:		Gender:	DOB:
City, State:	Zip:	Phone:	Language:
Caregiver Name:		Relationship:	Phone:
Emergency Contact:		Relationship:	Phone:
<b>Primary Insurance:</b>		<b>Secondary Insurance:</b>	
Subscriber:		Subscriber:	
Policy #:	Group #:	Policy #:	Group #:
Insurance Phone:		Insurance Phone:	

**Statement of Medical Necessity (please provide all information)**

**Primary Diagnosis:**  021.1 - Hyperemesis gravidarum with metabolic disturbances is 021.1  
 Other: ICD-10: \_\_\_\_\_ Description: \_\_\_\_\_

**Medical History:**  Diabetes  Peptic Ulcer Disease  Immunodeficiency  Cardiac Disease  Other: \_\_\_\_\_

**Allergies:**  NKDA  
 Pre-pregnancy Wt: \_\_\_\_\_  lbs  kg Date: \_\_\_\_\_  
 Pre-illness Wt: \_\_\_\_\_  lbs  kg Date: \_\_\_\_\_  
 G/P: \_\_\_\_\_ EDC: \_\_\_\_\_ Height: \_\_\_\_\_ Current Wt: \_\_\_\_\_  lbs  kg Date: \_\_\_\_\_

Did patient receive other medical therapies within the last 6 months?  Yes  No If yes, Date: \_\_\_\_\_

Current Medications: Attach to the patient's current medication profile

**Prescription (please check all that apply)**

<input type="checkbox"/> Intravenous hydration	<input type="checkbox"/> Fluid type: _____ <input type="checkbox"/> Rate of infusion: _____ <input type="checkbox"/> Duration of therapy: _____ Medications: _____
<input type="checkbox"/> Metoclopramide (Reglan®)	<input type="checkbox"/> 10 mg IV or IM initially, followed by _____ mg per hour continuous Subcutaneous infusion, may titrate up to _____ mg/hour for symptom control (average effective dose 1.28 mg/hour). <input type="checkbox"/> Other regimen: _____
<input type="checkbox"/> Ondansetron (Zofran®)	Intermittent: <input type="checkbox"/> 2 mg <input type="checkbox"/> 4 mg IV every 6 - 8 hours Continuous: <input type="checkbox"/> Titrate per patients response between _____ mg and _____ mg (Usual dosing 12 - 32 mg) per day <input type="checkbox"/> IV <input type="checkbox"/> Subcutaneous continuously via pump. Bolus: <input type="checkbox"/> _____ mg (1 - 4 mg) demand dose allowed every _____ hours, times doses. (Max demand dose is 4 mg per day)
<input type="checkbox"/> Parenteral Nutrition	Dietitian to assess patient and provide PN formula recommendations
<input type="checkbox"/> Other	

Is this the first dose?  Yes  No If No, date first dose given: \_\_\_\_\_  Start ASAP  Date of last dose: \_\_\_\_\_

**Orders (please check all that apply)**

**TEACHING:** Instruct patient/caregiver about all aspects of their therapy and the s/s of complications.

**NURSING VISITS:** Nurse to assess patient for status and response signs and symptoms every \_\_\_\_\_.

**TB status:**  Active TB  PPD (-) date: \_\_\_\_\_  Last CXR date: \_\_\_\_\_  Unknown DNR status:  Rc'd  N/A

**Access:**  Subcutaneous  Peripheral  Midline  PICC  Other: \_\_\_\_\_

**Catheter Maintenance:**  Option Care Health Infusion Protocol  Other: \_\_\_\_\_

**Labs:**  CBC w/ Differential  Albumin  LFT  Chem-7  Urine specific gravity  Urine ketones  Other: \_\_\_\_\_

**Frequency:**  Weekly  Other: \_\_\_\_\_

Other Orders:

Follow up with Prescriber scheduled for: \_\_\_\_\_

Option Care Health to follow patient progress including weight (patient to monitor every morning).

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:	Office Contact:
Address:	Hospital/Clinic:		NPI:
City, State:	Zip:	License:	UPIN:

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