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 _____XXX-XXX-XXXX_____.

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:
Primary Insurance:		**Secondary Insurance:**	
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)

☐ Intravenous hydration	☐ Fluid type: _____ ☐ Rate of infusion: _____ ☐ Duration of therapy: _____ Medications: _____
☐ Metclopramide **(Reglan®)**	☐ 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). ☐ Other regimen:
☐ Ondansetron **(Zofran®)**	Intermittent: ☐ 2 mg ☐ 4 mg IV every 6 - 8 hours Continuous: ☐ Titrate per patients response between mg and mg (Usual dosing 12 - 32 mg) per day ☐ IV ☐ Subcutaneous continuously via pump. Bolus: ☐ mg (1 - 4 mg) demand dose allowed every hours, times doses. (Max demand dose is 4 mg per day)
☐ Parenteral Nutrition	Dietitian to assess patient and provide PN formula recommendations
☐ 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:

