



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 **877-865-9133**.

Sincerely,
Option Care Health

HYPERTENSION IN PREGNANCY PRESCRIBER ORDER FORM

| | |
|---------------|----------------|
| Patient Name: | Date of Birth: |
|---------------|----------------|

Address:

| | | | | | |
|--------|---------|---|-------------------|-------------|--|
| Phone: | Height: | <input type="checkbox"/> in <input type="checkbox"/> cm | Pre-Pregnancy Wt: | Current Wt: | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
|--------|---------|---|-------------------|-------------|--|

Clinical Information

| | |
|--|--|
| ICD-10 & Description: <input type="checkbox"/> O14.9 Unspecified pre-eclampsia unspecified trimester <input type="checkbox"/> Other: _____ | <input type="checkbox"/> O16.1 Unspecified maternal hypertension 1st trimester <input type="checkbox"/> O16.2 Unspecified maternal hypertension 2nd trimester <input type="checkbox"/> O16.3 unspecified maternal hypertension 3rd trimester |
|--|--|

| | | |
|------|------|-----------------|
| G/P: | EDC: | Activity Level: |
|------|------|-----------------|

| Current Medications | Dose | Route | Freq | Current Medications | Dose | Route | Freq |
|---------------------|------|-------|------|---------------------|------|-------|------|
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

Order Form

| | |
|--|---|
| Blood Pressure Testing & Management | <u>BLOOD PRESSURE CHECKS (check all that apply):</u> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Bedtime <u>NOTIFY PRESCRIBER FOR:</u> Systolic Blood Pressure ≥ 140 mmHg and/or Diastolic Blood Pressure > 90 mmHg Or as ordered below: |
| Urine Protein Testing | Check urine protein daily <u>NOTIFY PRESCRIBER FOR:</u> urine protein ≥ 2+ or as ordered: |
| Daily Weights | Check weight daily <u>NOTIFY PRESCRIBER FOR:</u> >3-5lb weight gain in 1 week or as ordered: |

Ancillary Orders

- Skilled Nurse Visit (SNV) or TeleHealth Nurse Visit x1 to initiate plan of care; PRN up to 2 nurse visits for complications identified in telephonic assessments.
- Educate patient regarding diagnosis and signs/symptoms that should be reported: epigastric pain, headaches, visual disturbances, increase in swelling, generalized malaise.
- Option Care Women’s Health to follow patient progress via telephonic assessment of blood pressures, weight, urine protein, and signs/symptoms of pre-eclampsia. Provide 24/7 telephonic nurse availability throughout length of service.
- Educate patient on reporting of blood pressures, weight, and urine protein.
- Initiate service once benefits and eligibility verification have been completed, authorization obtained (as applicable), patient’s acceptance of financial responsibility (as applicable), patient availability to start service, and patient having necessary equipment (blood pressure cuff, scale, protein dipsticks).
- **Other:**

Referral/Discharge Plan: Discontinue therapy with provider discharge order or completion of designated program per insurance, patient refusal, noncompliance, or if delivery occurs.
Other:

I certify that the use of the indicated treatment is medically necessary, I will be supervising the patient’s treatment, and my state medical license is current and valid.

Prescriber Information

| | |
|---|----------------------------------|
| Prescriber Signature: | Date: |
| Prescriber Name: | NPI: |
| Address: | Office Contact: |
| City: State: Zip: | Direct Contact Number/Extension: |
| Phone: | Fax: |

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 don’t 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.