



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

NAUSEA AND VOMITING IN PREGNANCY PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:	
Address:			
Phone:	Height: _____ <input type="checkbox"/> in <input type="checkbox"/> cm	Pre-Pregnancy Wt: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	Current Wt: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis: <input type="checkbox"/> O21.1 Hyperemesis Gravidarum with metabolic disturbance <input type="checkbox"/> Other (ICD-10 Code & Description):			
G/P:	EDC:	Medications Tried/Failed for condition:	
# Hosp/ED visits for condition:		Hosp/Room #:	
Allergies:			
Current Medications	Dose	Route	Freq

Prescription Form

Continuous Pump Route: <input type="checkbox"/> Subcutaneous <input type="checkbox"/> PICC <input type="checkbox"/> Midline <input type="checkbox"/> Other:													
<input type="checkbox"/> PRESCRIPTION: ONDANSETRON (0.3mg/mL) Dispense 70mg/ 233mL 0.9% Sodium Chloride	<ul style="list-style-type: none"> ▪ Skilled nurse to begin infusion at 0.5mg per hour (12 mg per day). Pharmacy to dispense pump and all supplies required for infusion. ▪ Titrate dosage per patient response between 0.5 mg and 1.1 mg/hour. For change in symptoms, increase or decrease dose by 0.2 mg every 12 hours, not to exceed dosage of 1.1 mg/hr. ▪ PRN Bolus: 0.2 mg demand dose via pump allowed every 1 hour, times 24 doses in 24 hours. (Total Ondansetron dose not to exceed 32 mg per 24 hour) ▪ Administer Loading Dose of Ondansetron: <ul style="list-style-type: none"> ▪ PICC/midline: 8mg in 100mL bag of 0.9% Sodium Chloride IV x 1 dose; Infuse over 30 minutes (200mL/hr) ▪ Subcutaneous: 4mg Ondansetron IM x 1dose ▪ For patients with history of hepatic impairment, patient should have ALT and AST drawn prior to therapy and a minimum of every two weeks thereafter. Prescriber to order outpatient lab work with results called to HCP & reported to Option Care Women's Health 												
OR													
<input type="checkbox"/> PRESCRIPTION: METOCLOPRAMIDE (0.5mg/mL) Dispense 85mg/170mL 0.9% Sodium Chloride	<ul style="list-style-type: none"> ▪ Skilled nurse to begin infusion of 1 mg per hour (24 mg per day) via pump. Pharmacy to dispense pump and all supplies required for infusion. ▪ PRN Bolus: 0.6 mg demand dose via pump allowed every 1 hour, times 24 doses in 24 hours. (Total Metoclopramide dose not to exceed 40 mg per 24 hour) 												
<input type="checkbox"/> PRESCRIPTION: Dextrose 5% LR 1000mL or fluids as ordered below: <ul style="list-style-type: none"> ▪ Sodium Chloride 0.9% 10mL flush ▪ Heparin 10 units/mL 5mL flush ▪ Pharmacy to dispense needed supplies for hydration 	<ul style="list-style-type: none"> ▪ Skilled nurse to start and access peripheral line, train patient/caregiver to self-administer medication. If peripheral IV infiltrates or becomes inoperable, patient to notify call center nurse, who will provide guidance to discontinue IV. ▪ Administer 250mL bolus of ordered fluids, then infuse at 125mL/hr once every 8 hours x3 days. Once patient is tolerating oral fluids and ketones are negative, may discontinue IV. If patient develops ketones >1+, may restart IV per orders as directed. May repeat per episodic dehydration. Refill PRN x1 year. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:30%;">Access Device</th> <th style="width:30%;">NS Flush (0.9% NaCl)</th> <th style="width:40%;">Heparin Flush (10u/mL)</th> </tr> </thead> <tbody> <tr> <td>Peripheral IV</td> <td>3mL pre/post use</td> <td>2mL post-use (every 24 hours if not used)</td> </tr> <tr> <td>Midline IV</td> <td>5mL pre/post use</td> <td>3mL post-use (every 12 hours if not used)</td> </tr> <tr> <td>PICC & CVC</td> <td>5mL pre/post use; 5mL pre/10 mL post lab draw</td> <td>5mL post-use (every 24 hours if not used)</td> </tr> </tbody> </table>	Access Device	NS Flush (0.9% NaCl)	Heparin Flush (10u/mL)	Peripheral IV	3mL pre/post use	2mL post-use (every 24 hours if not used)	Midline IV	5mL pre/post use	3mL post-use (every 12 hours if not used)	PICC & CVC	5mL pre/post use; 5mL pre/10 mL post lab draw	5mL post-use (every 24 hours if not used)
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PICC & CVC	5mL pre/post use; 5mL pre/10 mL post lab draw	5mL post-use (every 24 hours if not used)											
<input type="checkbox"/> PRESCRIPTION: Benadryl 25mg, dispense 2 tabs	<ul style="list-style-type: none"> ▪ Patient or RN may administer Benadryl 25mg PO for mild allergic reaction. Pump to be turned off. May repeat x1 within 30 minutes. Prescriber to be notified. 												

Ancillary Orders

<input type="checkbox"/> Anaphylaxis Kit for 1st dose	<ul style="list-style-type: none"> ▪ If 1st dose exposure, Option Care Women's Health to send Anaphylaxis Prescriber Order Form for signature
<ul style="list-style-type: none"> ▪ Established PICC or Midline Care (if applicable) 	<ul style="list-style-type: none"> ▪ Change PICC/midline dressing every 7 days and PRN. Instruct patient to take temperature daily. Notify prescriber if temperature is greater than 100.4°F. RN to remove PICC/midline at end of therapy (where applicable)
<ul style="list-style-type: none"> ▪ May repeat skilled nursing visit or TeleHealth visit x1 to reinforce education and patient teaching needs. ▪ Option Care Women's Health nurse to telephonically assess patient while on service. Provide 24/7 telephonic nurse availability throughout length of service. ▪ Initiate Service once benefits & eligibility verification have been completed, patient's acceptance of financial responsibility (as applicable), and availability to start service. 	
Referral/Discharge Plan: Discontinue therapy with provider discharge order, once hyperemesis has been resolved, patient refusal, noncompliance, or if delivery occurs.	
<input type="checkbox"/> 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: