

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	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 <p style="text-align: center;">OR</p> <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 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 														
<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;"> <thead> <tr> <th style="width:25%;">Access Device</th> <th style="width:25%;">NS Flush (0.9% NaCl)</th> <th style="width:50%;">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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<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.	
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:

Fax completed form, insurance information, and clinical documentation to: 877-865-9133

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