NAUSEA AND VOMITING IN PREGNANCY PRESCRIBER ORDER FORM

PHONE: 888-304-1800

option care health™ | women's health

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

Patient Name:			**Date of Birth:**
Address:			
Phone:	**Height:** _____ ☐ in ☐ cm	**Pre-Pregnancy Wt:** _____ ☐ lb ☐ kg	**Current Wt:** _____ ☐ lbs ☐ kg

Enter patient's full demographics

Clinical Information

Primary Diagnosis: ☐ O21.1 Hyperemesis Gravidarum with metabolic disturbance ☐ Other (ICD-10 Code & Description):

Check ICD-10 code

G/P:	**EDC:**	**Tried/Failed for condition:**
# Hosp/ED visits for condition:	**Hosp/Room #:**	**Allergies:**

Fill out EDC

Current Medications	Dose	Route	Freq	Current Medications	Dose	Route	Freq

Prescription Form

Continuous Pump Route: ☐ Subcutaneous ☐ PICC ☐ Midline ☐ Other:

Check route for pump

☐ PRESCRIPTION:
ONDANSETRON (0.3mg/ml)
Dispense 70mg/
233ml Normal Saline

- 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:
  - PICC/midline: 8mg in 100ml bag of Normal Saline IV x 1 dose; Infuse over 30 minutes (200ml/hr)
  - Subcutaneous: 4mg Ondansetron IM x 1dose

OR

Select Zofran or Reglan

☐ PRESCRIPTION:
METOCLOPRAMIDE (0.5mg/ml)
Dispense 85mg/170ml Normal Saline

- Skilled nurse to begin infusion of 1.0 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)

☐ PRESCRIPTION:
Dextrose 5% LR 1000ml or fluids as ordered below:

- Sodium Chloride 0.9% 10ml flush
- Heparin 10 units/ml 5ml flush
- Pharmacy to dispense needed supplies for hydration

Select Hydration if ordered

- Skilled nurse to start and access peripheral line, train patient/ peripheral IV to notify call center continue IV.
- Administer ordered fluids 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.

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 post-use (every 24

☒ PRESCRIPTION:
Benadryl 25mg, dispense 2 tabs

- Patient or RN may administer Benadryl 25mg PO for mild allergic reaction. Pump t minutes. Prescriber to be notified.

Benadryl tab will be pre-checked for mild reaction

Anaphylaxis order will be sent if 1st dose

Ancillary Orders

☐ Anaphylaxis Kit for 1st dose	▪ If 1st dose exposure, Option Care Women's Health to send Anaphylaxis Prescriber
▪ Established PICC or Midline Care (if applicable)	▪ Change PICC/midline dressing every 7 days and PRN. Instruct patient to take tempe is greater than 100.4°F. RN to remove PICC/midline at end of therapy (where applicable)

- 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 verificatio ty (as applicable), and availability to start service.

Referral/Discharge Plan: Discontinue therapy with pr refusal, noncompliance, or if delivery occurs.

- Other:

Complete full prescriber information section (stamped signatures not accepted)

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:

Incomplete order form may result in a delay of processing referral