

Cert Period: _____ to _____

Home Infusion Post Acute Prescriber Order Form

To: Option Care Health		Phone:		Fax:		Date:									
From:		Phone: X		Fax:		# Pages, Incl. Cover:									
Patient Name:			Patient Phone:		DOB:		Gender:								
Address:			City:		State:		Zip:								
Medicare ID # (if applicable) _____ ☐ Patient is homebound per Medicare criteria Please attach the following: demographics; insurance information; H&P; medication profile															
Diagnosis(es) or Problems Related to or Requiring the Need for Option Care Health Services															
Clinical Background and Orders															
1	Ht: _____ ☐ In ☐ cm Wt: _____ ☐ lb ☐ kg Date: _____ Code Status: _____ IV Access: _____ Allergies: ☐ NKDA or (list): _____ ☐ Advance Directives														
2	Rehab Potential: ☐ Full ☐ Partial ☐ Terminal ☐ Palliative Care Mental Status: ☐ Alert/Oriented ☐ Confused ☐ Depressed Safety Measures: ☐ 911/EMS ☐ Standard Precautions ☐ Med Storage Hazard ☐ Hazardous Waste ☐ Electrical Emergency ☐ Disaster Diet: ☐ Regular ☐ ADA ☐ Cardiac ☐ Other _____ Functional Limitations: _____ Prescription: Drug (Additional drugs listed on separate attachment, if necessary) Directions Prognosis ☐ _____ GM IV Q _____ H X _____ Days ☐ Excellent ☐ Fair ☐ Good ☐ _____ IV Q _____ H X _____ Days ☐ Poor ☐ Guarded ☐ _____ IV Q _____ H X _____ Days Adverse Reaction Orders: ☐ If first dose, check here and include Treatment Guidelines and Physicians Order for Adult Drug Related Adverse Reactions														
3	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">Catheter Maintenance, Supply and Nursing Orders:</th> <th style="width:15%;">Indicated Access Device to be Utilized</th> <th style="width:20%;">NS Flush (0.9% NaCl)</th> <th style="width:25%;">Heparin</th> </tr> </thead> <tbody> <tr> <td> - Option Care Health to provide IV catheter maintenance therapy for non-treatment days as needed. - Indicate appropriate flushing protocol by checking the appropriate item(s) - Provide all supplies necessary to administer therapy ☐ Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x 1 per incident of sluggish/occluded line. Qty: #2 ☐ Skilled nurse to train patient/caregiver to self-administer medication, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADRs, and administer medications as ordered. RN to discontinue venous access at completion of therapy. ☐ RN to pull PICC line at end of therapy - SN Visit Frequency: _____ with _____ PRN Visits for: _____ - SN to assess with each patient visit: ☐ Response to Therapy ☐ Instruction Needs ☐ Compliance ☐ Home Safety ☐ Pain Level ☐ Physical Assessment ☐ Virtual/In Person </td> <td> ☐ Peripheral ☐ Peripheral-Midline ☐ PICC & Central Tunneled & Non-tunneled ☐ Implanted Port ☐ Valved Catheters: Chest, PICC, Midline </td> <td> ☐ 2 - 3 ml pre/post use ☐ 3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw ☐ 5 ml pre/post use; 5 ml pre/10 ml post lab draw ☐ 5 - 10 ml pre/post infusion; 10 - 20 ml pre/post lab draw ☐ 5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly </td> <td> ☐ 1 - 3 ml (heparin 10 units/ml) post-use or every 24 hrs if not used ☐ 3 ml (heparin 10 units/ml) post-use or every 12 hours if not used ☐ 3 ml (heparin 100 units/ml) post-use or every 24 hrs if not used ☐ 3 ml (heparin 100 units/ml) post-use or every 24 hours if not used ☐ 5 ml (heparin 10 units/ml) post-use or every 24 hours if not used ☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used ☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed N/A </td> </tr> </tbody> </table>							Catheter Maintenance, Supply and Nursing Orders:	Indicated Access Device to be Utilized	NS Flush (0.9% NaCl)	Heparin	- Option Care Health to provide IV catheter maintenance therapy for non-treatment days as needed. - Indicate appropriate flushing protocol by checking the appropriate item(s) - Provide all supplies necessary to administer therapy ☐ Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x 1 per incident of sluggish/occluded line. Qty: #2 ☐ Skilled nurse to train patient/caregiver to self-administer medication, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADRs, and administer medications as ordered. RN to discontinue venous access at completion of therapy. ☐ RN to pull PICC line at end of therapy - SN Visit Frequency: _____ with _____ PRN Visits for: _____ - SN to assess with each patient visit: ☐ Response to Therapy ☐ Instruction Needs ☐ Compliance ☐ Home Safety ☐ Pain Level ☐ Physical Assessment ☐ Virtual/In Person	☐ Peripheral ☐ Peripheral-Midline ☐ PICC & Central Tunneled & Non-tunneled ☐ Implanted Port ☐ Valved Catheters: Chest, PICC, Midline	☐ 2 - 3 ml pre/post use ☐ 3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw ☐ 5 ml pre/post use; 5 ml pre/10 ml post lab draw ☐ 5 - 10 ml pre/post infusion; 10 - 20 ml pre/post lab draw ☐ 5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	☐ 1 - 3 ml (heparin 10 units/ml) post-use or every 24 hrs if not used ☐ 3 ml (heparin 10 units/ml) post-use or every 12 hours if not used ☐ 3 ml (heparin 100 units/ml) post-use or every 24 hrs if not used ☐ 3 ml (heparin 100 units/ml) post-use or every 24 hours if not used ☐ 5 ml (heparin 10 units/ml) post-use or every 24 hours if not used ☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used ☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed N/A
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4	Lab and Other Orders: ☐ Discharge Plans: Discharge from home health services when goals are met and/or therapy completed. ☐ Discharge to care of self / family / caregiver with MD follow-up														

5 Goals:

- ☐ Patient/Caregiver will demonstrate safe administration of Rx therapy. Will achieve ☐ Partial ☐ Complete independence in therapy as applicable.
- ☐ Patient/Caregiver will verbalize potential side effects and/or complications of therapy to report and appropriate action as required.
- ☐ Patient/Caregiver will demonstrate correct care and maintenance of access device: ☐ IV ☐ Enteral ☐ Subcutaneous ☐ Other: _____
- ☐ Infusion access device will remain free from infection or other complications. ☐ Resolve/Improve infection(s): _____
- ☐ Therapy will be tolerated without adverse event ☐ Patient will maintain/improve activity level ☐ Patient will demonstrate improved mobility.
- ☐ Nutritional status ☐ Fluid/electrolyte balance will be maintained/improved as evidenced by labs WNL, weight stabilization and/or improved clinical condition. ☐ Patient's HAE symptoms shall be adequately controlled with adverse reaction prevented or recognized and minimized.
- ☐ Patient's pain level, on a scale of 0 - 10, will be at an acceptable level to the patient of: _____
- ☐ Other: _____

I certify that the use of the indicated treatment is medically necessary.

Prescriber Signature: _____ **Date:** _____

Prescriber Name: _____	Prescriber NPI: _____
Address: _____	Office Contact: _____
City: _____ State: _____ Zip: _____	Direct Contact Number/Extension: _____
Phone: _____ Fax: _____	

Fax Orders to:

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.