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:
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

Catheter Maintenance, Supply and Nursing Orders:

- 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

Indicated Access Device to be Utilized	NS Flush (0.9% NaCl)	Heparin
☐ Peripheral	☐ 2 - 3 ml pre/post use	☐ 1 - 3 ml (heparin 10 units/ml) post-use or every 24 hrs if not used
☐ Peripheral-Midline	☐ 3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	☐ 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
☐ PICC & Central Tunneled & Non-tunneled	☐ 5 ml pre/post use; 5 ml pre/10 ml post lab draw	☐ 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
☐ Implanted Port	☐ 5 - 10 ml pre/post infusion; 10 - 20 ml pre/ post lab draw	☐ 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
☐ Valved Catheters: Chest, PICC, Midline	☐ 5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

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: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Prescriber NPI: _____
Office Contact: _____
Direct Contact Number/Extension: _____

Fax Orders to:

