MENINGOCOCCAL VACCINE PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**
Address:	

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Encounter for immunization | **ICD-10 Code:** Z23

Meningococcal Vaccine Prescription

MENINGOCOCCAL VACCINATIONS ARE INDICATED FOR PATIENTS, INCLUDING PEOPLE OVER 25 YEARS OF AGE, WHEN ON A COMPLEMENT INHIBITOR TREATMENT.

☐ **Option 1: MenACWY (2 dose series) AND MenB (3 dose series)** **ONE (1) REQUIRED FROM EACH GROUP FOR EACH SERIES**			☐ **Option 2: Pentavalent (2-3 dose series)**
Choose Brand	Meningococcal Groups (MenACWY) ☐ **Menveo** OR ☐ **Menquadfi**	Meningococcal Groups (MenB) ☐ **Bexsero** OR ☐ **Trumenba**	Meningococcal Groups (MenABCWY) **Penbraya-** ☐ **2 Dose** or ☐ **3 Dose**
Initial Series Dose	Inject MenACWY vaccine 0.5 mL IM x 1 at day 0	Inject MenB vaccine 0.5 mL IM x 1 at day 0	**2 DOSE SERIES:** **1)** Inject **Penbraya** vaccine 0.5 mL IM x 1 at day 0 **2)** Inject **Penbraya** vaccine 0.5 mL IM x 1 (6 months after day 0)
2nd Dose in Series	Inject MenACWY vaccine 0.5 mL IM x 1 (8 weeks after day 0)	Inject MenB vaccine 0.5 mL IM x 1 (1-2 months after day 0)	**3 DOSE SERIES:** **1)** Inject **Penbraya** vaccine 0.5 mL IM x 1 at day 0 **2)** Inject MenACWY vaccine 0.5 mL IM x 1 (8 weeks after day 0) ☐ Menveo OR ☐ Menquadfi **And** Inject **Trumenba** vaccine 0.5 mL IM x 1 (1-2 months after day 0)
3rd Dose in Series	**N/A**	Inject MenB vaccine 0.5 mL IM x 1 (6 months after day 0)	**3)** Inject **Trumenba** vaccine 0.5 mL IM x 1 (6 months after day 0)

☐ **Option 3: Booster Dose**		
☐ **Menveo** OR ☐ **Menquadfi** Inject MenACWY vaccine 0.5 mL IM x1 (Booster) **MenACWY- every 5 years while on complement inhibitors**	☐ **Bexsero** OR ☐ **Trumenba** Inject MenB vaccine 0.5 mL IM x 1 (Booster) **MenB: 1 year after initial series then every 2-3 years while on complement Inhibitor**	☐ Inject **Penbraya** vaccine 0.5 mL IM x 1 (Booster) Use only when MenACWY and MenB are indicated at the same visit. **Trumenba must be the initial series.**

CPT Codes: 90620 – MenB vaccine, 90734 – MenACWY vaccine, 90460 – vaccine administration

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health policy. The following items will be dispensed:

☒ Diphenhydramine 50 mg/mL 1 mL vial x 1. Inject 25 mg IM PRN for allergic reaction. May repeat x 1 dose in 15 min PRN if no improvement

☒ 0.9% Sodium Chloride 500 mL bag x 1. Infuse 500 mL IV at KVO rate PRN anaphylaxis.

☒ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.

General Anaphylaxis Instructions

1. Administer emergency meds as ordered
2. Administer epinephrine as above and repeat dose if necessary.
3. Administer injectable diphenhydramine as above and repeat dose if necessary.
4. Place peripheral IV and administer 0.9% Sodium Chloride.
5. Initiate CPR if needed.
6. Call EMS (activate the emergency medical system).
7. Monitor vital signs – elevate legs if hypotensive.
8. Notify prescriber and nurse or pharmacist.

Skilled nurse to administer vaccination series.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: **(800) 420-5150**

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