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

	Meningococcal Groups (MenACWY) ☐ **Menveo** OR ☐ **Menquadfi**	Meningococcal Groups (MenB) ☐ **Bexsero** OR ☐ **Trumenba**
Choose Brand		
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
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)
3rd Dose in Series	**N/A**	Inject MenB vaccine 0.5 mL IM x 1 (6 months after day 0)

☐ **Option 2: Pentavalent (2-3 dose series)**

Meningococcal Groups (MenABCWY) ☐ **Penbraya** - ☐ **2 Dose** or ☐ **3 Dose**	Meningococcal Groups (MenABCWY) ☐ **Penmenvy** - ☐ **2 Dose** or ☐ **3 Dose**
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)	**2 DOSE SERIES:** **1)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 at day 0 **2)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 (6 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) **3)** Inject **Trumenba** vaccine 0.5 mL IM x 1 (6 months after day 0)	**3 DOSE SERIES:** **1)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 at day 0 **2)** Inject Menveo vaccine 0.5 mL IM x 1 (8 weeks after day 0) **And** Inject **Bexsero** vaccine 0.5 mL IM x 1 (1-2 months after day 0) **3)** Inject **Bexsero** vaccine 0.5 mL IM x 1 (6 months after day 0)

☐ **Option 3: Booster Dose**

☐ **Menveo** OR ☐ **Menquadfi**	☐ **Bexsero** OR ☐ **Trumenba**	☐ **Penbraya** or ☐ **Penmenvy**
Inject MenACWY vaccine 0.5 mL IM x1 (Booster) **MenACWY- every 5 years while on complement inhibitors**	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 MenABCWY 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 for Penbraya.** **Bexsero must be the initial series for Penmenvy.**

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.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.
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

