

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

Choose Brand	Meningococcal Groups (MenACWY) <input type="checkbox"/> Menveo OR <input type="checkbox"/> Menquadfi	Meningococcal Groups (MenB) <input type="checkbox"/> Bexsero OR <input type="checkbox"/> Trumenba
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 nd 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 rd 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) <input type="checkbox"/> Penbraya - <input type="checkbox"/> 2 Dose or <input type="checkbox"/> 3 Dose	Meningococcal Groups (MenABCWY) <input type="checkbox"/> Penmenvy - <input type="checkbox"/> 2 Dose or <input type="checkbox"/> 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) <input type="checkbox"/> Menveo OR <input type="checkbox"/> 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**

<input type="checkbox"/> Menveo OR <input type="checkbox"/> Menquadfi Inject MenACWY vaccine 0.5 mL IM x1 (Booster) MenACWY- every 5 years while on complement inhibitors	<input type="checkbox"/> Bexsero OR <input type="checkbox"/> 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	<input type="checkbox"/> Penbraya or <input type="checkbox"/> Penmenvy 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.
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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**

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