

MENINGOCOCCAL VACCINE PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
----------------------	-----------------------	----------------

Address:

Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> 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
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) <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.
--	---	--

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.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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

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.