# MENINGOCOCCAL VACCINE PRESCRIBER ORDER FORM

| Patient Name: | Date of Birth: | Gender: |
|---|---|---|
| **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:**<br>**1)** Inject **Penbraya** vaccine 0.5 mL IM x 1 at day 0<br>**2)** Inject **Penbraya** vaccine 0.5 mL IM x 1 (6 months after day 0) | **2 DOSE SERIES:**<br>**1)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 at day 0<br>**2)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 (6 months after day 0) |
| **3 DOSE SERIES:**<br>**1)** Inject **Penbraya** vaccine 0.5 mL IM x 1 at day 0<br>**2)** Inject MenACWY vaccine 0.5 mL IM x 1 (8 weeks after day 0)<br>☐ Menveo OR ☐ Menquadfi<br>**And**<br>Inject **Trumenba** vaccine 0.5 mL IM x 1 ( 1-2 months after day 0)<br>**3)** Inject **Trumenba** vaccine 0.5 mL IM x 1 (6 months after day 0) | **3 DOSE SERIES:**<br>**1)** Inject **Penmenvy** vaccine 0.5 mL IM x 1 at day 0<br>**2)** Inject Menveo vaccine 0.5 mL IM x 1 (8 weeks after day 0)<br>**And**<br>Inject **Bexsero** vaccine 0.5 mL IM x 1 ( 1-2 months after day 0)<br>**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)<br>**MenACWY- every 5 years while on complement inhibitors** | Inject MenB vaccine 0.5 mL IM x 1 (Booster)<br>**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)<br>**Use only when MenACWY and MenB are indicated at the same visit.**<br>**Trumenba must be the initial series for Penbraya.**<br>**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**



 