HOME INFUSION PHARMACY PRESCRIBER ORDER FORM

Pharmacy Name:	Address:	Ph:

option care health

Prescriber/Practice Group/Health System Name:				
Patient Name:		**Date of Birth:**		
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies:	

Prescription

Please indicate medication, dose, frequency, route, and length of therapy:

Ancillary Orders

IV Flush Orders

☐	Peripheral:	NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.
☐	For Maintenance *(select one)*:	☐ NS 2 to 3 mL every 12 hr ***or*** ☐ heparin (10 unit/mL) 1 to 3 mL every 24 hr.
☐	Peripheral-Midline:	NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 3 mL post-use.
☐	For Maintenance *(select one)*:	Heparin ☐ (10 unit/mL) 3 mL every 12 hr ***or*** ☐ (100 unit/mL) 3 mL every 24 hr.
☐	PICC and Central Tunneled/Non-Tunneled: *(select one)*	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL ***or*** ☐ (100 unit/mL) post-use.
☐	For Maintenance *(select one)*:	Heparin ☐ (10 unit/mL) 5 mL ***or*** ☐ (100 unit/mL) 3 mL every 24 hr.
☐	Implanted Port:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.
☐	Valved Catheters:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 5 to 10 mL at least weekly.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

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:**

