# VAXFIRST PRESCRIBER ORDER FORM

**Fax completed form, insurance information, and clinical documentation to: (800) 420-5150**

| **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 |
|---|---|

## Vaccination Orders

**Vaccine Formulation Selection** *[Choose applicable vaccination(s) from one of the following options.]*

Meningococcal Group B (MenB) Vaccines

- ☐ Bexsero
- ☐ Trumenba®

Meningococcal Groups A, C, W, and Y (MenACWY) Vaccines

- ☐ MenQuadfi
- ☐ Menveo®

**Meningococcal Vaccination Primary Series Initiation or Booster Dose**

- ☐ Inject MenB vaccine 0.5 mL IM x 1
- ☐ Inject MenACWY vaccine 0.5 mL IM x 1

**Meningococcal Vaccination Primary Series Completion** *[Choose applicable vaccination(s) from one of the following options.]*

**Option No. 1**

Injection(s) on Day 60

- ☐ Inject MenB vaccine 0.5 mL IM x 1
- ☐ Inject MenACWY vaccine 0.5 mL IM x 1

**Option No. 2**

Injection on Day 30

- ☐ Inject MenB vaccine 0.5 mL IM x 1

Injection on Day 60

- ☐ Inject MenACWY vaccine 0.5 mL IM x 1

CPT Codes: 90620 – MenB vaccine, 90734 – MenACWY vaccine, 90460 – vaccine administration

## Ancillary Orders

**Anaphylaxis Kit**

➔ Required per Option Care 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.
- ☒ NS 500 mL bag x 1. Infuse 500 mL IV at KVO rate PRN anaphylaxis.
- ☒ Epinephrine ampule/vial 1 mg/mL (1:1000) 1 mL x 2 ampules/vials. Inject 0.3 mg SQ PRN for adverse reaction. May repeat x 1 dose in 5 to 15 min PRN.

**General Anaphylaxis Instructions**

1. Administer emergency meds as ordered
2. Administer epinephrine as above and repeat dose if necessary.
3. Administer injectable diphenhydramine as above and repeat dose if necessary.
4. Place peripheral IV and administer NS.
5. Initiate CPR if needed.
6. Call EMS (activate the emergency medical system).
7. Monitor vital signs – elevate legs if hypotensive.
8. Notify prescriber and Option Care Director Nursing or pharmacist.

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:** | |

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