Home Infusion General Order Form

*****Please fax all pages with a copy of medical history and recent labs to (888) 388-1309*******

For Inquiries call: **Georgia** prescribers line: **(844) 803-2220** **All other** prescribers:**(844) 598-2557**

Patient Information

Date of Birth:	Patient name:	☐ Male ☐ Female
Requested Start of Care Date:	Height:	Weight (kg):
Address:	City: State:	Zip:
Allergies:		

Clinical Information

Primary Diagnosis Description:_____ Primary ICD-10 Code: _____

Secondary Diagnosis Description _____ Secondary ICD-10 Code: _____

Prescription

Medication Name:_____ Dose/Strength:_____

Directions:_____

_____

_____

Dispense quantity sufficient Refill for 1 Year

Ancillary and Premedication Orders / Other Orders- Dispense PRN X 1 year

☐ **Anaphylaxis Kit**

- Diphenhydramine Tab Administer 50 mg PO x1. May repeat once if symptoms persist.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN if no improvement.
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours

Pre-Medication Orders

☐ Methylprednisolone sodium succinate _____ mg IV 30 min prior to infusion.

☐ Diphenhydramine _____ mg PO 30 min before infusion.

☐ Acetaminophen _____ mg PO 30 min before infusion.

☐ Other:_____

IV Flush Orders

☐ Peripheral: NS 5 mL pre-/post-use.

☐ Implanted Port: • NS 5 to 10 mL pre-/post-use • Heparin (100 unit/mL) 5 mL post-use

For maintenance, every 24 hr if accessed or weekly to monthly if not accessed.

Nursing Order: Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year. RN to flush IV post infusion

Ancillary supplies: Ancillary supplies, including a disposable IV pole, for the via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump. Ancillary supplies include tubing and pump for subcutaneously administered drugs.

Prescriber Information

Name:_____ **Practice:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____ **Fax:**_____ **NPI:**_____ **Contact:**

_____ _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy.

_____ _____ _____

Substitution permissible signature **Dispense as written signature** **Date**