



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: | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Requested Start of Care Date: | Height: | Weight (kg): | |
| Address: | City: | State: | Zip: |
| Allergies: | | Phone Number: | |

| 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