HOME INFUSION PHARMACY PRESCRIBER ORDER FORM

Pharmacy Name:	**Address:**	**Ph:**

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

Access Device	0.9% NaCl Flush	Heparin
Peripheral IV	☐ 2-3 mL pre/post infusion ☐ 2-3 mL every 12 hours for maintenance	☐ N/A ☐ 1-3 mL heparin (10 units/mL) every 24 hours for maintenance
Peripheral- Midline	☐ 3-5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	☐ 3 mL heparin (10 units/mL) post-use or every 12 hours if not used ☐ 3 mL heparin (10 units/mL) post-use or 3 mL heparin (100 units/mL) every 24 hours for maintenance
PICC & Central Tunneled & Non-tunneled	☐ 5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	☐ 5 ml (heparin 10 units/ml) post use or every 24 hours if not used ☐ 3 ml (heparin 100 units/ml) post use or every 24 hours if not used
Implanted Port	☐ 5 - 10 ml pre/post infusion, 10 - 20 ml pre/ post lab draw	☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used ☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
Valved Catheters: Chest, PICC, Midline	☐ 5 - 10 ml pre/post use, 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

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:**

