HOME INFUSION PHARMACY PRESCRIBER ORDER FORM							
Fax completed form, insurance information, and clinical documentation to:							
≅ INTELLIGENT	Patient Name:	tient Name:			Date of Birth:		
E HEALTH COMPANY.	Address:						
UBACARE	Phone:		Height:	☐ inches ☐ c	m 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, \square NS 2 to 3 mL every 12 hr \underline{or} \square heparin (10 unit/mL) 1 to 3 mL every 24 hr.				
☐ <u>Peripheral-Midline:</u>		NS 3 to 5 m Heparin (10 For mainter	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, heparin \Box (10 unit/mL) 3 mL every 12 hr \underline{or} \Box (100 unit/mL) 3 mL every 24 hr.				
☐ PICC and Central Tunneled/Non-Tunneled:		: NS 5 mL pre Heparin □	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin \square (10 unit/mL) 5 mL \underline{or} \square (100 unit/mL) post-use. For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.				
☐ <u>Implanted Port:</u>		NS 5 to 10 r Heparin (10 For mainter	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.				
☐ <u>Valved Catheters:</u>		NS 5 to 10 r	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 or	dered at this time.						
□ Other:							
	s and administer and/or teach s support as needed. Refill above			via access devic	e as indicated abo	ve. Nurse	
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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