



Nausea and Vomiting of Pregnancy (Ondansetron) Prescription for Home Administration

Fax signed form to: **866-252-4293** or **866-731-9011** OR scan signed form to **OBHIntake@optum.com**

NOTE: Copy of current **INSURANCE CARD (front & back)** must accompany submission. Initiate & manage homecare per Optum Protocols (<https://optum.com/obhomecareprotocols>) OR call Optum @ **800-950-3963** for other orders.

Form Completed by (Name, Title, Phone): _____

Patient Name:						Phone:
Address:				City/St./Zip:		
DOB:	Due Date:	Ht:	Wt:	PP Wt:	Email:	
Preferred Language:	<input type="checkbox"/> English	<input type="checkbox"/> Other	Allergies:			
Pt. Current Location:	<input type="checkbox"/> Home	<input type="checkbox"/> Hospital (name)				
Insurance Info: (Carrier, Policy #, Phone #)						

Service Requested	Criteria for Service (Check all that apply)
<p style="text-align: center;">Service start will occur upon verification, patient acceptance, and receipt of medication.</p> <p><input type="checkbox"/> ONDANSETRON NVP MANAGEMENT via CONTINUOUS SQ PUMP: Use Optum dosing guidelines for initial dosing/bolus and ongoing management. Titrate basal within 14.4 to 38.4 mg/day; bolus doses of 1mg (0.5ml SQ) each 4 hours apart, initial bolus dose 2-4mg IM per dosing guidelines. Discontinue oral ondansetron when pump is started, resume PRN when pump is suspended or interrupted. Wean and discharge per protocol.</p>	<input type="checkbox"/> Failed the following oral medications to treat NVP: <input type="checkbox"/> Ondansetron <input type="checkbox"/> Metoclopramide <input type="checkbox"/> Diclegis <input type="checkbox"/> _____ <input type="checkbox"/> Weight loss of _____ lbs. <input type="checkbox"/> Failure to gain weight <input type="checkbox"/> Ketone (+) <input type="checkbox"/> Minimal/No food intake <input type="checkbox"/> Frequent vomiting episodes <input type="checkbox"/> ER/Hospitalization: # of times: _____ <input type="checkbox"/> Homebound <input type="checkbox"/> Decreased ability to perform ADL's/work
<p><input type="checkbox"/> ONDANSETRON NVP MANAGEMENT via EXISTING PICC: Use Optum dosing guidelines for initial dosing/bolus and ongoing management. Titrate basal within 14.4 to 38.4 mg/day; bolus doses of 1-2mg each 4 hours apart, initial bolus dose 2-4mg per dosing guidelines. Flush with normal saline 5 to 10ml PRN & heparin (100units/ml) 5ml PRN. Dressing changes weekly & PRN. Discontinue oral ondansetron when pump is started, resume PRN when pump is suspended or interrupted. Wean and discharge per protocol. MUST PROVIDE DOCUMENTATION THAT TIP IS IN DISTAL SUPERIOR VENA CAVA or NEAR THE CAVOATRIAL JUNCTION.</p>	
<p><input type="checkbox"/> Add Hydration In addition to above checked service (Hydration is not available as a stand-alone service)</p> <p><input type="checkbox"/> Initiate peripheral IV at start of care, 500ml bolus then 125ml/hr up to 4 days or until patency is compromised. Select fluid below. May flush with normal saline 2 to 5ml PRN. Patient to discontinue IV line if not infusing.</p> <p>Choose One <input type="checkbox"/> Via existing PICC or MIDLINE: 500ml bolus then 125ml/hr, flush with normal saline 5 to 10ml PRN & (PICC ONLY) heparin (100units/ml) 5ml PRN. May continue IVH past 4 days if patent & symptoms of dehydration are present. IV dressing change weekly & PRN.</p>	
<p>Choose Fluid & Additive</p> <p><input type="checkbox"/> D5LR <input type="checkbox"/> Normal Saline <input type="checkbox"/> Lactated Ringers <input type="checkbox"/> D5 1/2 NS</p> <p><input type="checkbox"/> Thiamine 100mg <input type="checkbox"/> Multivitamin 10ml to 1 liter daily (may substitute 5ml pediatric)</p> <p><input type="checkbox"/> Single lumen PICC – add to 100ml mini bag daily</p> <p><input type="checkbox"/> Peripheral IV or double lumen PICC – add to 1 liter daily</p>	

Initial Prescriber (Signature Required)

I certify that this patient is under my care and that the above services are medically necessary and are authorized by me with the above written plan of treatment. My signature acknowledges that (i) I have received and reviewed the protocol that accompanies this plan of treatment and understand and accept responsibility for the patient's care, and (ii) my state medical license is current and valid as indicated below. *Please provide email for Plan of care receipt/signature."

Prescriber Signature: _____ **Print Name:** _____

Select One: Primary OB MFM Hospitalist (Patient will not start home care until ongoing provider sends signed Rx)

NPI#: _____ **License#:** _____ **State:** _____ **Date:** _____

Practice Name:	Office Contact:		
Address:	City/St./Zip:		
Phone:	Fax:	MD Email:	

If ongoing care of this patient will be managed by another provider, complete the information below. As the prescriber, you are responsible for full care of this patient unless/until ongoing managing provider's prescription is received by Optum. At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued, until such time physician above is responsible for patient.

Ongoing Provider's Name: _____ **Phone:** _____

FOR INTERNAL USE ONLY	Telephone Order From:		
	RBV by Optum Nurse:	Date:	Time:
	RX Reviewed by Optum Nurse:	Date:	