

## 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 as provided for following services OR call Optum @ **800-950-3963** for other orders.

Form Com	pleted by (Nai	me, Title, Phone	e):							
Patient Name:								Phone:		
Address:						City/St./Zip:				
DOB:		Due Date:		Height:		Weight	:	Pre-pregna Weight:	ant	
Preferred Language:	English ()ther					Allergies:				
Pt. Current Location:	Home	Home Hospital (name)								
Insurance Info: (C Policy #, Phone #										
Service Requested  Service start will occur upon verification, patient acceptance, and receipt of						edicatio	n.		iteria for Service Check all that apply)	
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.  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.  MUST PROVIDE DOCUMENTATION THAT TIP IS IN SUPERIOR VENA CAVA.								Failed the following oral medications to treat NVP: Ondansetron Metoclopramide Diclegis  Weight loss of lbs. Failure to gain weight Ketone (+)		
Add Hydration In addition to above checked service (Hydration is not available as a stand-alone service)  Initiate peripheral IV at start of care, 500ml bolus then 125ml/hr up to 4 days or until patency is										
Choose One	compromised. Select fluid below. May flush with normal saline 2 to 5ml PRN. F not infusing. Via existing PICC or MIDLINE: 500ml bolus then 125ml/hr,flush with normal sal ONLY) heparin (100units/ml) 5ml PRN. May continue IVH past 4 days if patent are present. IV dressing change weekly & PRN.					Patient to discontinue IV line if ine 5 to 10ml PRN & (PICC		Minimal/No food intake  Frequent vomiting episodes  ER/Hospitalization: # of times:		
Choose	D5LR Thiamine 100mg Single lumen F	Normal Saline PICC – add to 100ml	Lactate	ed Ringers			liter daily (may	Dec	mebound creased ability to perform L's/work	
	Peripheral IV o	or double lumen PICC		•	Signature Re	auire	d)			
My signature a for the patient's	icknowledges that s care, and (ii) my	(i) I have received a state medical license	above services nd reviewed the e is current and	are medic protocol the valid as inc	ally necessary a nat accompanies dicated below.	nd are a this pla	authorized by me with in of treatment and u	nderstand	e written plan of treatment. and accept responsibility	
Prescriber Signature:  NPI#: License #:										
NPI#: License #:           Practice Name:						Office Contact:				
Address:						City/St./Zip:				
Phone: Fax:						Email:				
care of this pa will be transfe	atient unless/unt erred to the alterr	il ongoing managin nate provider and th	g provider's pr ne initial patien	escription t care pres	is received by scription is disc	Optum ontinu	At that time, all cared.	re respons	re responsible for full sibilities for this patient	
Provider's Name: Phone:  Telephone Order From:										
FOR INTERNAL USE ONLY	, ,	RBV by Optum Nurse:					Date:		Time:	
	RX Reviewed by							Date:		

Optum Nurse: