Optum

Nausea and Vomiting of Pregnancy (Metoclopramide) 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 Completed by (Name, Title, Phone): _____

Patient Name:				Phone:
Address:			City/St./Zip:	
DOB:	Due Date:	Height:	Weight:	Pre-pregnant Weight:
Preferred Language: ☐ English ☐ Other			Allergies:	
Pt. Current Location: ☐ Home ☐ Hospital (name)				
Insurance Info: (Carrier, Policy #, Phone #)				

Service Requested

Service start will occur upon verification, patient acceptance, and receipt of medication.

☐ **METOCLOPRAMIDE NVP MANAGEMENT via CONTINUOUS SQ PUMP:**
Use Optum dosing guidelines for initial dosing/bolus and ongoing management. Titrate basal rate within 12 to 60 mg/day; bolus doses within 3 - 5mg each 4 hours apart, initial bolus dose of 5 - 10mg IM. Dispense 2 diphenhydramine 25mg tablets for first time drug exposure or for patient with history of severe allergic reaction, patient will be directed to take in the event of mild/moderate S/E or EPS. Discontinue oral metoclopramide when pump is started, resume PRN when pump is suspended or interrupted.

☐ **METOCLOPRAMIDE NVP MANAGEMENT via EXISTING PICC:**
Use Optum dosing guidelines for initial dosing/bolus and ongoing management. Titrate basal rate within 12 to 60 mg/day; bolus doses of 3-5mg each 4 hours apart, initial bolus dose of 5-10mg per dosing guidelines. Flush with normal saline 5-10ml PRN and heparin (100units/ml) 5ml PRN. Dispense 2 diphenhydramine 25mg tablets for first time drug exposure or for patient with history of severe allergic reaction, patient will be directed to take in the event of mild/moderate S/E or EPS. Discontinue oral metoclopramide when pump is started, resume PRN when pump is suspended or interrupted. **MUST PROVIDE DOCUMENTATION THAT TIP IS IN SUPERIOR VENA CAVA.**

☐ **Add Hydration** In addition to above checked service **(Hydration is not available as a stand-alone service)**

Choose One
- ☐ 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.
- ☐ 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.

Choose Fluid & Additive
- ☐ D5LR ☐ Normal Saline ☐ Lactated Ringers ☐ D5 ½ NS
- ☐ Thiamine 100mg to 1 liter daily ☐ Multivitamin 10ml to 1 liter daily (may substitute 5ml pediatric)

Criteria for Service

(Check all that apply)

- ☐ Failed the following oral medications to treat NVP:
  - ☐ Ondansetron
  - ☐ Metoclopramide
  - ☐ Diclegis
  - ☐ _____
- ☐ Weight loss of _____ lbs.
- ☐ Failure to gain weight
- ☐ Ketone (+)
- ☐ Minimal/No food intake
- ☐ Frequent vomiting episodes
- ☐ ER/Hospitalization: # of times: _____
- ☐ Homebound
- ☐ Decreased ability to perform ADL's/work

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.

Prescriber Signature: _____ Print Name:_____

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

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

Provider's Name: _____ Phone: _____

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