

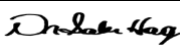


Home Infusion Therapy Plan of Care

Vyepti

Agency Info		Elite Infusion Care- NPI 1760148456 Fax- 424-349-0011 Phone- 714-519-6993 Address: 1440 Harbor Blvd Ste 916 Fullerton, CA Email- Admin@Eliteinfusioncare.com	
Patient Name:			
Date of birth			
Advance Directive (s)	<input type="checkbox"/> None <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Living Will <input type="checkbox"/> Copy Requested		
Reason for Plan of Care	<input type="checkbox"/> Initial <input type="checkbox"/> Change in Response to treatment <input type="checkbox"/> Refill Request <input type="checkbox"/> MD order Change		
Plan of Care Development Participation	Patient Participated in the establishment/Maintenance of POC		
Service Location Type	<input type="checkbox"/> In- Home <input type="checkbox"/> Physician Office/Clinic		
Ordering Physician		NPI	
Allergies	<input type="checkbox"/> NKDA <input type="checkbox"/> List _____		
Diagnosis			
In Office Infusion Therapy Rejected by Patient	<input type="checkbox"/> Yes <input type="checkbox"/> NO		
Start of Care		# of Refills	
Medication Order	<input type="checkbox"/> Vyepti 100 MG/100 ML NS <input type="checkbox"/> Vyepti 300 MG/100 ML NS		
Dose Frequency	Every 3 months		
Rate of infusion (ML/HR)	Infuse over estimated 30 minutes		
Mode of Administration	Gravity IV or IV pump		
Pre-medication #1			
Pre-medication #2			
Pre-Medication #3			
Additional Orders			
Anaphylaxis Protocol	<ul style="list-style-type: none"> •Epinephrine 1:1000 concentration 0.3 ML Sub Q up to 3 doses 15-20 Mins •Benadryl 50 MG IV/po Over 5-10 Min x1 Per Agency/or Pharmacy Protocol 		<ol style="list-style-type: none"> 1.STOP infusion. 2.Administer emergency meds as ordered. 3.Administer epinephrine as above and repeat dose if necessary. 4.Administer injectable diphenhydramine as above. If IV line is in place. 5.Initiate CPR (if needed). 6.Call EMS (activate the emergency medical system). 7.Monitor vital signs every 15 mins – elevate legs if hypotensive. 9.Notify prescriber and Director of Nurse/RN Supervisor and pharmacist

Physician Notification Parameters	Temperature	Blood Pressure	Heart Rate	Respirations	Glucose	Weight
	Temp <96.8 f > 100.4f	SBP <90 or > 150 Diastolic >90	HR < 55 or >110	Resp <12 or >24	glucose <65 >200	> 2 lb/day or >5 lb/week
Functional Limits	<input type="checkbox"/> None Identified <input type="checkbox"/> Blindness <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Ambulating <input type="checkbox"/> Cognitive/Mental					
Safety concerns	<input type="checkbox"/> None Identified <input type="checkbox"/> Fall <input type="checkbox"/> Infection Risk <input type="checkbox"/>					
Diet/Nutritional Needs	<input type="checkbox"/> None Identified <input type="checkbox"/> NPO <input type="checkbox"/> G-Tube <input type="checkbox"/> Other					
Nursing Services	Infusion Services by RN					
	Frequency: RN to Visit every 3 months					
	Duration: 1 year					
	Nurse to Review Patient Medication History, Maintain Medication Profile, Physical, Mental and environment Assessment, Teaching and Education, Monitor response and adherence to treatment					
Lab Collection	<input type="checkbox"/> Lab Collection-Not Ordered					
	Test Ordered	<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> BMP <input type="checkbox"/> CRP <input type="checkbox"/> Other_____				
	Frequency	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other_____				
	Method of Collection	Nurse may collect using syringe or Vacuum Assistive device(Luer Lock Attachment), Nurse to collect Via vein-puncture or central line Access Device				
IV insertion	Insert peripheral IV or may use Central Line if present.					
Nurse IV removal	RN to remove Peripheral IV after infusion- DO not remove Central Line unless additional orders received					
Nursing Administration instruction	* Use 0.2 or 0.22 Micron in line filter during infusion *flush lie with 20 ML normal saline after infusion					
Patient Specific Therapy Goals	<input type="checkbox"/> Decrease or complete absence of Migraines <input type="checkbox"/> Prevent Progression of Disease Prevent Adverse Drug Reactions During Services <input type="checkbox"/> Maintenance of quality of Life					
Discharge Plans	<input type="checkbox"/> Life Long Treatment <input type="checkbox"/> D/C when therapy complete <input type="checkbox"/> D/C when symptoms Stabilized <input type="checkbox"/> D/C to Self injection therapy when loading doses complete					
Equipment/ Supply Needs	SubQ access insertion Supplies, SubQ Pump, all other Administration Supplies					

RN Print Name		Date Signed	
RN Signature			
Ordering/Physician		Signature	Date
Medical Director	Dr. Saba Haq,MD	Signature	
By Signing (Medical Director)I have reviewed the POC w/nursing staff to ensure POC meet 2 CCR § 74697 requirements and for the initiation of agency protocol orders. All Changes to Primary Medication will require orders from Ordering physician			