pharmacy SPECIALISTS

P: 877.217.3619 • F: 877.220.6086
pharmacy-specialists.com

Home Parenteral Nutrition (TPN) Order Form

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name		Date of Birth		Gender	☐ Male ☐ Female
Address					
Home Phone		Work Phone		Cell Phone	

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg)		Height		Allergies	
Diagnosis				Date	
Patient Status	☐ New to Therapy ☐ Continuing Therapy			Next Treatment Date	
Line Access	☐ Port ☐ PICC Other: _____			Lumens	☐ 1 ☐ 2 ☐ 3

TPN MANAGEMENT

Check one TPN management option below:

☐ ***Pharmacy Specialists* managed TPN:** *Pharmacy Specialists Parenteral Nutrition Team* will provide evidence-based, customized home parenteral nutrition management to optimize patient outcomes. By checking this box, you have authorized the *Pharmacy Specialists Parenteral Nutrition Team* to assess and write orders for the initial TPN formula and/or make ongoing changes to an existing parenteral nutrition prescription. Parenteral nutrition changes will include adjustments to macronutrients and micronutrients, parenteral nutrition volume, rate and duration of infusion, lab order management, and home health coordination. The treating provider will be notified of all parenteral nutrition therapy changes and will be required to sign a detailed written order acknowledging parenteral nutrition therapy changes.

☐ **Treating provider managed parenteral nutrition:** *Pharmacy Specialists* will not provide recommendations for changes including nutrition formula and lab order management. Pharmacy Specialists will continue to coordinate home health and provide lab results to the prescriber. The treating provider is required to notify the Pharmacy Specialists Nutrition Team weekly if there will be any changes to a current parenteral nutrition prescription. **(See PAGE 2)**

ADDITIONAL ORDERS

Lab Orders:

☐ CBC w/ diff, CMP (BMP + LFTs), mag, phos, triglycerides weekly

☐ Other _____

Flush Orders:

- Sodium Chloride 0.9% Flush 5-10ml pre/post infusion PRN.
- Heparin 10u/ml or Heparin 100u/ml per protocol as indicated PRN.

- Skilled Nurse to assess, teach and train self-administration of Parenteral Nutrition to patient and/or caregiver
- Refill parenteral nutrition orders as directed 1 year.

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name		Signature		Date	
Prescriber NPI		Phone		Fax	Contact Person

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MACRONUTRIENTS

Amino Acids: _____ gm/day

Amino Acid Type: _____

Dextrose: _____ gm/day

Lipids: _____ gm/day

Lipid Type: _____

Lipid Days: _____ days/week

Total TPN Volume: _____ mL

Infuse Over: _____ mL/hr

Continuous TPN Rate: _____ mL/hr

Cycling Rate: _____ mL/hr

Taper Up: _____ hour(s)

Taper Down: _____ hour(s)

ELECTROLYTES

Sodium Chloride: _____ mEq/day

Sodium Acetate: _____ mEq/day

Sodium Phosphate: _____ mMol/day

Potassium Chloride: _____ mEq/day

Potassium Acetate: _____ mEq/day

Potassium Phosphate: _____ mMol/day

Magnesium Sulfate: _____ mEq/day

Calcium Gluconate: _____ mEq/day

Additional Additives

Adult Multivitamin (10mL/day): _____ mL/day

Trace Element Solution (1 mL/day): _____ mL/day

Folic acid: _____ mL/day

Other: _____

REQUIRED INFORMATION

Length of Need Statement (LON)

- MUST be included in a progress note and signed by the prescriber
- Example of LON: "Due to patient's [condition], TPN is needed for [insert amount of time here]."
- Medicare requires patient to have a permanent impairment considered long and indefinite in duration
- Note: Medicare does recognize time frames such as "lifetime" as appropriate

Must also include enteral contraindication

- What prevents patient from having a feeding tube?

REFERRAL AND INSURANCE APPROVAL PROCESS: Please submit a completed order form and all required documentation. *Pharmacy Specialists* will complete insurance verification and submit all required documentation to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. Financial responsibility will be reviewed with the patient. Any available co-pay assistance programs will be discussed with the patient as needed. Thank you for the referral.

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Prescriber Name _____ Signature _____ Date _____

Prescriber NPI _____ Phone _____ Fax _____ Contact Person _____