PREECLAMPSIA SERVICES– effective AUG 2022

****PRESCRIPTION FORM FOR OB HOMECARE SERVICES****

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

NOTE: COPY OF CURRENT INSURANCE CARD (FRONT AND BACK) MUST ACCOMPANY THIS SUBMISSION. Initiate and manage homecare **PER OPTUM PROTOCOLS** as provided for the following services OR physician to call Optum (800-950-3963) for other orders.

PATIENT INFORMATION

Name: ______________________________ Phone: ______________

Address: ______________________________ City: ______________ State: _____ Zip Code: _______

D.O.B. ________ Due Date: ________ Ht: _____ Wt: _____ Allergies: ______________________________

Patient Location (at time of referral): ❑ Home ❑Hospital (name):______________________________

Preferred Language: ❑ English ❑ Other: ________________________

Insurance Carrier Name, Policy #, phone #: ______________________________

Form completed by: (Name, title): ______________________________ Phone #: ____________

SERVICE REQUESTED (check all that apply) START OF SERVICE WILL OCCUR UPON VERIFICATION AND PATIENT ACCEPTS CAARE	**BASED ON THE FOLLOWING CRITERIA** (CHECK ALL THAT APPLY)
❑ **AT RISK for PREECLAMPSIA SURVEILLANCE** (*patient does not need high blood pressure to be at risk*): For patients *at risk* for developing preeclampsia at or more than 20 weeks' gestation — may accept prescription beginning at 16 weeks' gestation.	❑ History of preeclampsia ❑ Gestational hypertension ❑ Chronic hypertension ❑ Other combined risk factors
❑ **PREECLAMPSIA SURVEILLANCE with 14-DAY POSTPARTUM FOLLOW-UP:** For patients *diagnosed with* preeclampsia characterized by more than 1 occurrence of BP greater than or equal to 140 AND/OR 90; PLUS, proteinuria at or more than 20 weeks' gestation — may accept prescription beginning at 16 weeks' gestation.	❑ Preeclampsia without severe features ❑ Highest recorded BPs: ______________
❑ **14-DAY POSTPARTUM FOLLOW-UP PREECLAMPSIA SURVEILLANCE:** For patients *not currently* on Optum preeclampsia services, diagnosed *AT DELIVERY* with preeclampsia or at risk for preeclampsia exacerbation.	❑ At risk for preeclampsia or preeclampsia exacerbation postpartum. ❑ Highest recorded BPs: ______________
❑ Patient Arm Circumference if known: ________ cm	

Initial Prescriber (Signature Required)

Practice Name: ______________________________ Office contact: ______________________

Address: ______________________________ City: ____________________ State: ______ Zip code: _______

Phone Extension: ________________________ Fax: ________________________ Email: ____________________________

IF ONGOING CARE OF THIS PATIENT WILL BE MANAGED BY ANOTHER PROVIDER, COMPLETE THE INFORMATION BELOW. <u>As the prescriber, you are responsible for full care of this patient unless/until the ongoing managing provider's prescription is received by Optum.</u> At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued.

Providers Name: ______________________________ Phone: ________________________

Address: ______________________________ City: ____________________ State: _____ Zip code: ______

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. Start of service will occur upon completion of benefits of eligibility, verification, receipt of medication from dispensing pharmacy and patient agreement to start of service date.

PRESCRIBER SIGNATURE:______________________________ (Print Name): __________________________

NPI#:____________________________ License#: ___________________________ State: ________ Date: ________

For Internal Use Only: Telephone Order From: ______________________________

❑ RBV By (Optum Nurse): ____________________________, RN Date: __________ Time: _________

❑ Prescription reviewed by Optum RN: ________________________________ Date: ______________

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