Optum

Preeclampsia Services – 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:
Preferred Language: English Other		Allergies:	
Pt. Current Location: Home Hospital (name)			Patient Arm Circumference: (If known, in CM)
Insurance Info: (Carrier, Policy #, Phone #)			

Service Requested

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

At Risk for Preeclampsia and Early Gestation Hypertension Surveillance

per Optum protocol

- For patients ≥ 20 weeks gestation at risk for developing preeclampsia.
- For patients < 20 weeks gestation requiring blood pressure (BP) surveillance.

Add Postpartum Preeclampsia Surveillance (14 day)

Criteria (check all that apply)

- History of preeclampsia
- Gestation hypertension
- Chronic hypertension
- Other combined risk factors

Increase in BP may not be present

Preeclampsia Surveillance with postpartum follow-up (14 day) per Optum protocol

- For patients ≥ 20 weeks gestation diagnosed with preeclampsia, characterized by more than 1 occurrence of BP ≥ 140 and/or 90 and proteinuria.
- For patients ≥ 20 weeks gestation meeting BP criteria for preeclampsia and have preexisting chronic proteinuria.

We do not accept patients with severe features

Postpartum Preeclampsia Surveillance (14 day) per Optum protocol

- For patients *not currently* on Optum services diagnosed with preeclampsia at delivery.
- For patients *not currently* on Optum services and at risk for postpartum preeclampsia.

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:

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