PRGORD Progress & Order

PeaceHealth

Peace Harbor Medical Center
Outpatient Infusion Service Request

Phone: (541) 902-6019 Fax: (541) 902-1649

Thank you for selecting our infusion services team to care for your patient. If you are not a PeaceHealth provider, all information listed below is required before we can process orders and schedule your patient for treatment.

Part A- Patient scheduling and contact information:

Patient Name (Last, First): _____Date of Birth: _____

Patient Contact Information and Phone Number(s): _____

Ordering Provider Name (Print): _____

Provider Clinic or Service Address: _____

Clinic or Service Phone Number: _____ Clinic or Service Fax Number: _____

Diagnosis (include ICD 10 codes): _____

Medication and Service Requested- list J-Code/CPT code if known: _____

Date Service is Requested to Begin: _____ **Date Service is Expected to End**: _____

Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.

Part B- Insurance and Prior Authorization. Any non-PeaceHealth provider must obtain prior authorization prior to service. *Attach a copy of authorization documentation received from insurance payer when submitting orders.*

Insurance (Payer) Company: _____

Prior Authorization Number and Conditions: _____

Prior Authorization Expiration Date: _____

Insurance (Payer) Contact Phone Number: _____

Part C- Elements needed to guide medication therapy are included with request for service:

☐ All orders and instruction (please use the PeaceHealth approved ordering form) are complete and include provider signature AND printed name at the bottom of each order page. Check the boxes of ALL orders you would like to activate.

☐ For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

If information is located outside of PeaceHealth's electronic medical record system attach the following:

☐ A list of current medications reconciled by patient provider is available and includes a list of known allergies.

☐ Recent progress notes from ordering provider.

☐ A copy of relevant laboratory results and other appropriate supporting documentation.

IMPORTANT MESSAGE TO PROVIDERS: To reduce delays in treatment and phone calls to your office you may participate in the PHMC formulary process by signing this document. A clinical pharmacist will adjust orders according to PHMC approved policies and procedures.

I agree to utilize PHMC policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PHMC. This agreement will be issued for the duration of active orders contained within this treatment plan.

PROVIDER SIGNATURE: _____ DATE: _____ TIME:_____

FAX completed service request and completed orders to: PHMC OP Infusion and Nursing Services 541-902-1649

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Certolizumab (Cimzia)
Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
For Admission to Service	**Provider Instruction –** Please review information below and address requirements for admission to service: 1. Provider has screened for tuberculosis, hepatitis B, and acute or chronic infections prior to initiation. **Date of negative screening (required for service)**: _____ 2. Provide patient with the FDA approved medication guide for certolizumab (Cimzia).
Supportive Care	☒ **Certolizumab pegol (Cimzia)** subcutaneous injection: **Initiation Regimen** (for new patients): ☐ 400 mg administered at 0, 2 and 4 weeks **(indicate maintenance regimen below)** **Maintenance Regimen** (for established patients): ☐ 400 mg every 4 weeks ☐ 200 mg every 2 weeks ☐ _____ mg every _____ weeks (indicate dose and frequency)
Labs	☐ **Initiation** 1. CBC with automated differential at baseline, month 4, and month 12 of therapy 2. Comprehensive metabolic panel at baseline, month 4, and month 12 of therapy ☐ **Maintenance** (labs recommended every 3-6 months) 1. CBC with automated differential every _____ months 2. Comprehensive metabolic panel every _____ months ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
Nursing Orders	☒ CBC with differential and CMP should be baseline, month 4, and month 12 of therapy. Labs after that are every 3-6 months based on provider preference. Do not wait for lab results to proceed with treatment. ☒ For doses of 400 mg, administer as 2 x 200 mg at separate subcutaneous sites (thigh or abdomen) ☒ Monitor patient for signs and symptoms of infection and notify provider if present before administration of certolizumab. ☒ Monitor patient for 15 minutes post injection for signs and symptoms of reaction. For reaction, administer emergency medications and notify provider.
Emergency Medications	**If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.** ☒ **DiphenhydrAMINE (Benadryl)** injection 25-50 mg IM once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (greater than or equal to 20 points in SBP), nausea, urticaria, chills, pruritis). • Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction • Administer 25 mg IM if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IM dose for a total of 50 mg and notify provider. ☒ **Albuterol 90 mcg/actuation** inhaler 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available.

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.

Patient Identification Label

PeaceHealth
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Outpatient Infusion Therapy Plan

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Heading	Content
	☒ **MethylPREDNISolone (Solu-Medrol)** injection 125 mg IM once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (greater than or equal to 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl) and notify provider. Do not inject into deltoid. ☒ **EPINEPHrine (Adrenalin)** injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (greater than or equal to 40 points in SBP), shortness of breath with wheezing and 02 Sat less than 90%) and notify provider.
Referral	☒ Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	**PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:** **PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department** 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX ***541-902-1649***
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ ☐ Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.