*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

# Darbepoetin (Aranesp)
# 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 address the following:<br>1. Correct preexisting iron, B12 and/or folate deficiencies prior to therapy.<br>2. Provider has screened patient for uncontrolled hypertension, seizures, heart failure, coronary heart disease and stroke prior to initiating therapy.<br>3. Provide patient with the FDA approved medication guide for darbepoetin (Aranesp). |
| **Supportive Care** | ☒ **Goal of treatment –** Hemoglobin level of 10-11 g/dL. Hemoglobin must be below 10 g/dL on initiation<br>**Choose one of the following (A-C):**<br>A. **Initiation orders for patients with CKD not on dialysis:**<br>☐ Darbepoetin alpha-polysorbate (Aranesp) injection 0.45 mcg/kg subcutaneous every **2 weeks.**<br>☐ Darbepoetin alpha-polysorbate (Aranesp) injection 0.45 mcg/kg subcutaneous every **4 weeks.**<br>B. **Maintenance orders to continue current dose (renewal of expired orders):**<br>☐ Continue darbepoetin alpha-polysorbate (Aranesp) subcutaneous injection at current dose<br>C. **Other Indications:**<br>☐ Darbepoetin alpha-polysorbate (Aranesp) injection _____ (indicate dose) subcutaneous every _____ (indicate frequency)<br>**Additional order instruction:**<br>☒ Dose of darbepoetin (Aranesp) may be rounded to the nearest manufacturer's unit of use syringe.<br>☒ Pharmacist to adjust dose to maintain therapeutic goal using the following dosing guidelines: |
| **Nursing Orders** | ☒ Hold if hemoglobin exceeds 11 g/dL.<br>☒ Patients receiving concurrent treatment with iron sucrose (Venofer) and/or vitamin B12 cannot receive an erythropoiesis stimulating agent treatment on the same day.<br>☒ Hold and contact provider if blood pressure is greater than 160/90 mmHg. |
| **Labs** | ☒ Hemoglobin and hematocrit once prior to beginning treatment and every 7 days for weekly dosing, every 14 days for every 2-week dosing, or every 28 days for every 4-week dosing.<br>☐ Iron Deficiency Panel once prior to beginning treatment and every 84 days<br>☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date. |

| Chronic Renal Failure | Dose Titration |
|---|---|
| Hgb concentration of 10-11 g/dL (inclusive) | Therapeutic goal |
| Hgb increase is less than 1 g/dL after 4 weeks of therapy and iron stores are adequate | Increase darbepoetin dose up to 25%; do not increase dose more frequently than every 4 weeks |
| Hgb increase is greater than or equal to 1 g/dL in a 2-week period, or greater than 2 g/dL in a 4-week period | Reduce darbepoetin dose by 25% to 50% |
| If Hgb is increasing and approaching 11 g/dL | Reduce darbepoetin dose by as much as 25% |
| Hgb is greater than 11 g/dL | Hold darbepoetin dose until Hgb drops to 11 g/dL. Restart darbepoetin at 75 % of the previous dose |
| If patient dose not attain target Hgb range 10-11 g/dL within 12 weeks | Do not continue to increase darbepoetin dose; may require reassessment for other causes of anemia; notify provider for reassessment. |

**Practitioner Signature: _____Date of Order: _____Time: _____**

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

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

# Darbepoetin (Aranesp)
# 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 |
|---|---|
| **Referral** | ☒ Ambulatory referral to OP Infusion Services |
| **PHMC Outpatient Infusion Contact Information** | **PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:**<br>**PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department**<br>400 Ninth Street Florence, OR 97439<br>Contact Phone: 541-902-6019 and FAX ***541-902-1649*** |
| **Authorization by Verbal or Telephone Order** | Person giving verbal or telephone order: _____<br>Person receiving verbal or telephone order: _____<br>☐ 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.*