



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**

**\*PRGORD\***

Progress & Orders



Patient Identification Label

## Filgrastim (Neupogen) and Biosimilar Agents 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
Supportive Care	<input checked="" type="checkbox"/> Filgrastim subcutaneous injection, OR <input checked="" type="checkbox"/> Provider authorizes use of a filgrastim biosimilar per facility and patient insurance formulary requirements. <b>Select Dose:</b> <input type="checkbox"/> 300 mcg <input type="checkbox"/> 480 mcg <b>Select Frequency:</b> <input type="checkbox"/> Once (single dose) <input type="checkbox"/> Other (please specify): _____
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b>  <b>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department</b> 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX <b>541-902-1649</b>
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ <input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy

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**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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