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

InFLIXimab and Biosimilars
Outpatient Infusion Therapy Plan
Initiation and Maintenance

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 and address requirements for admission to service: 1. Provider has screened patient for history of chronic infection, heart failure, seizure disorder, liver disease, tuberculosis, blood dyscrasias, hepatitis (hepatitis B surface antigen and hepatitis B core antibody), or malignancy prior to initiation of inFLIXimab therapy. ***Date of screening (required for service):*** _____. 2. Provide patient with FDA approved inFLIXimab medication guide.
Labs	☐ CBC with automated differential once prior to starting treatment and every _____ weeks ☐ Comprehensive metabolic panel once prior to starting treatment and every _____ weeks ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
Pre-Medications	☒ Acetaminophen (Tylenol) 650 mg PO once prior to infusion ☒ Loratadine (Claritin) 10 mg PO once prior to infusion ☐ MethylPREDNISolone sodium succinate (Solu-MEDROL) 40 mg IV once prior to infusion
Supportive Care	**Select Medication:** ☐ **InFLIXimab-dyyb (Inflectra)** IV infusion (formulary preferred agent); **OR** ☐ InFLIXimab-abda (Renflexis) IV infusion; **OR** ☐ InFLIXimab (Remicade) IV infusion **Select Dose** (Dosing will be rounded to nearest vial size): ***Weight-based Dose*** ***Other*** ☐ 5 mg/kg ☐ _____ (indicate dose) ☐ 3 mg/kg **Select Frequency**: **For new patients beginning inFLIXimab therapy:** ☐ Initiation regimen given at 0, 2 and 6 weeks *followed by* maintenance infusion every 8 weeks ☐ Initiation regimen given at 0, 2 and 6 weeks *followed by* maintenance infusion every _____weeks **For established patients on maintenance therapy:** ☐ Maintenance infusion every 8 weeks ☐ Maintenance infusion every _____ weeks (indicate frequency) **Additional order instruction:** ☒ Use an in-line, sterile, non-pyrogenic, low protein-binding filter with 1.2-micron pore size or less.

INFUSION RATE SCHEDULE	
Time (minutes)	**Infusion Rate**
0	Initiate at 10 mL/hr x 15 min
15	Increase to 20 mL/hr x 15 min
30	Increase to 40 mL/hr x 15 min
45	Increase to 80 mL/hr x 15 min
60	Increase to 150 mL/hr x 15 min
90	Increase to 250 mL/hr until done

Practitioner Signature: _____Date of Order: _____Time: _____

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Nursing Communication	☒ For new patients beginning inFLIXimab therapy: • Prior to starting inFLIXimab therapy ensure patient has had a recent PPD. If positive PPD and patient has not received isoniazid therapy, consult with physician regarding initiation of isoniazid therapy. • Infusion # 1-4: Vitals prior to infusion, before each rate increase, 30 minutes following infusion. Observe patient 30 minutes after completion of infusion. ☒ For ongoing maintenance therapy: • Infusion # 5-8: Vitals prior to infusion, 30 minutes after initiation, at end of infusion, and 30 minutes following infusion. Observe patient 30 minutes after completion of infusion. • Infusion # 9: Vitals prior to infusion, at end of infusion, and 30 minutes following infusion. Observe patient 30 minutes after completion of infusion. • Infusion # 10 and beyond: Vitals prior to infusion and end of infusion. No observation required upon completion of infusion.
Nursing IV Access and Maintenance	**Select the most appropriate option below:** ☒ **Insert PERIPHERAL IV** once as needed ☒ Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care ☐ **Access and use NON-PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate Central Line (Non-PICC) maintenance protocol ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access ☒ Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter. Reconstitute with 2.2 mL sterile water for injection to the vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix by gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Instill medication in non-functional lumen. Do not use lumen while dwelling. Allow to dwell 30 minutes and check for patency by drawing back on lumen for blood return. If line is still not patent, allow medication to dwell an additional 90 minutes. Dwell time not to exceed 120 minutes. Use second dose of Alteplase (Cathflo) if catheter not patent after 120 minutes. If the catheter is functional, aspirate and waste the medication and residual clot prior to flushing line. ☐ **Access and use PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate PICC maintenance protocol ☒ Change PICC line dressing weekly and as needed ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter

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As Needed Medications	☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care. ☒ Sodium chloride 0.9% continuous infusion IV at 25 mL/hour as needed for line care/therapy administration.
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.** **Standard Emergency Medications:** ☒ **DiphenhydrAMINE (Benadryl)** injection 25-50 mg IV once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritis) • Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction • Administer 25 mg IV if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IV 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 notify provider. Administer with a spacer if available. ☒ **MethylPREDNISolone (Solu-Medrol)** injection 125 mg IV 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 (>/= 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist after administration of diphenhydramine (Benadryl) and notify provider. ☒ **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 (>/= 40 points in SBP), shortness of breath with wheezing and 02 Sat < 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: _____

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