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

Ocrelizumab (Ocrevus)
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 patient for active hepatitis B virus infection, latent hepatitis and tuberculosis infections in high-risk populations, malignancy, and history of chronic infections prior to initiation of Ocrevus. 2. Ocrevus is contraindicated in patients with an active hepatitis B infection. Hepatitis B screening is required before first dose. Please order hepatitis B screening labs outside of this therapy plan prior to ordering Ocrevus. Order hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc Total). **Date of screening (required for service)**: _____ 3. Provider has verified that patient is up to date with all immunizations prior to initiation of Ocrevus. Live vaccines must be given at least 4 weeks prior to initiation of Ocrevus, and non-live vaccines must be given at least 2 weeks prior to initiation of Ocrevus. 4. Instruct patients that if they are pregnant or plan to become pregnant while taking Ocrevus, they should inform their healthcare provider.
Labs	☐ CBC with automated differential once prior to beginning treatment and every _____ months ☐ Comprehensive metabolic panel once prior to beginning treatment and every _____ months ☐ Other: _____
Pre-Medications	☒ MethylPREDNISolone sodium succinate (Solu-MEDROL) 125 mg IV once 30 minutes prior to infusion ☒ Acetaminophen (Tylenol) 650 mg PO once 30 minutes prior to infusion ☒ DiphenhydrAMINE (Benadryl) 25 mg PO once 30 minutes prior to infusion
Supportive Ca	☒ **Ocrelizumab (Ocrevus)** IV infusion: **Select Regimen**: ☐ **Initiation**: 300 mg at 0 and 2 weeks followed by 600 mg maintenance infusion every 6 months ☐ **Maintenance**: 600 mg every 6 months **Additional order instruction:** ☒ Administer through a dedicated IV line using a 0.2 or 0.22 micron in-line filter. For 300 mg doses begin infusion at 30 ml/hour and increase by 30 ml/hour every 30 minutes to a maximum rate of 180 ml/hour. For 600 mg doses begin infusion at 40 ml/hour and increase by 40 ml/hour every 30 minutes to a maximum rate of 200 ml/hour.
Nursing Orders	☒ Ocrevus is contraindicated in patients with an active hepatitis B infection. On initial visit, document that hepatitis B screening is complete. ☒ Assess for infection; notify ordering provide of need to delay administration for active infection. ☒ Vital signs to be done at baseline, as needed, and prior to discharge. ☒ Observe patients for infusion reactions during and for at least one hour after completion of infusion. ☒ MILD TO MODERATE INFUSION REACTIONS: Reduce infusion to one-half of the rate at which the reaction occurred; maintain reduced rate for at least 30 minutes. If the reduced rate is tolerated, increase rate every 30 minutes by 30 ml/hour to a maximum rate of 180 ml/hour (300 mg dose) or 40 ml/hour to a maximum rate of 200 ml/hour (600 mg dose).

Practitioner Signature: _____Date of Order: _____Time: _____

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

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Heading	Content
Nursing Orders	☒ SEVERE INFUSION REACTIONS: Immediately interrupt infusion, notify provider and administer appropriate supportive management as needed. After symptoms have resolved, restart infusion beginning at a rate one-half of the rate at the onset of reaction. If reduced rate is tolerated, increase the rate as above. ☒ LIFE-THREATENING INFUSION REACTIONS: Immediately stop infusion, notify provider, and administer appropriate supportive care. Permanently discontinue.
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: 1mg/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
As Needed Medications	☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care ☒ Sodium chloride 0.9% 500 mL continuous infusion at 25 mL/hour IV as needed for line care

Practitioner Signature: _____Date of Order: _____Time: _____

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

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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: _____

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