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

Rabies Post Exposure
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 –** Review information below and address requirements for admission to service: 1. Rabies immune globulin (RIG) is not for use in persons with a history of vaccination (preexposure or postexposure) and documentation of adequate antibody response. If rabies vaccine was initiated without rabies immune globulin, rabies immune globulin may be administered through the seventh (7^{th}) day after the administration of the first dose of the vaccine (day 0). Administration of RIG is not recommended after the seventh (7^{th}) day post vaccine since an antibody response to the vaccine is expected during this period. 2. Patients under the age of 18 should be referred to the emergency department for evaluation and initial treatment (day 0). 3. Administration of the rabies vaccine series to patients under the age of 14 may require special accommodation for administration in the emergency department ensuring the availability of pediatric advanced life support (PALS) trained nursing staff.
Supportive Care	☐ **Rabies Immune Globulin (HyperRAB)** 300 unit/mL injection - 20 units/kg IM once on day zero (0) **IF NOT PREVIOUSLY VACCINATED.** • Administer at an anatomical site distant from vaccine • If no bite/wound exists or if pre-exposure, then administer in deltoid muscle. If bite present, then administer around the bite/wound and in deltoid. • For infants and small children, administer in the anterolateral thigh in divided doses. • Note: This medication is manufactured using blood products. ☒ **Rabies Vaccine (Imovax/Rabavert)** injection (select one option below): • Adult IM injections in deltoid muscle only. Smaller children and infants may also use vastus lateralis. • WARNING – DO NOT administer in the gluteal muscle due to incomplete absorption. ☐ **Immunocompetent:** 2.5 units IM on days 0, 3, 7, and 14 (total of 4 doses). ☐ **Immunocompromised:** 2.5 units IM on days 0, 3, 7, 14, and 28 (total of 5 doses). ☐ **Previously vaccinated (ACIP recommended preexposure or postexposure vaccination regimen OR another vaccine regimen with documentation of adequate rabies antibody titer):** 2.5 units IM on days 0 and 3 (total of 2 doses).
Nursing Orders	☒ Give patient/parent the CDC vaccine information sheet for rabies vaccine on first visit. ☒ Rabies Immune Globulin (RIG) administration: • **IF NOT PREVIOUSLY VACCINATED.** • IF WOUND PRESENT: Infiltrate as much RIG into and around wound(s) as possible. Inject remaining RIG intramuscularly in site remote from wound. Adult IM injections in deltoid muscle only. Use anterolateral thigh or vastus lateralis in infants and smaller children. • IF NO WOUND PRESENT: Give one time dose IM in divided doses. Adult IM injections in deltoid muscle only. Infants and smaller children: vastus lateralis or anterolateral thigh ☒ Rabies Vaccine administration: • If previously vaccinated or if documented antibody response, only 2 doses are needed: day 0 and day 3. • Inject vaccine at anatomical site distant from where RIG was administered. Deltoid muscle in adults and adolescents; anterolateral thigh or vastus lateralis in infants and small children. • DO NOT administer in the gluteal muscle due to incomplete absorption. ☒ Discharge if stable 20 minutes after injection with appropriate follow up instructions.

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

Rabies Post Exposure
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
Emergency Medications	**If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling) initiate standard emergency response procedures.** ☒ **Standard ADULT Emergency Medications:** ☒ **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. ☒ **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. ☒ **Standard PEDIATRIC Emergency Medications - Call provider prior to administering if medication reaction occurs:** ☒ **EPINEPHrine (Adrenalin)** 1 mg/mL injection 0.15-0.3 mg IM every 5 minutes as needed for ongoing anaphylaxis symptoms. The dose may be repeated as needed every 5-15 minutes. • If less than 30 kg, give 0.15 mg (0.15 mL). If greater than or equal to 30 kg, give 0.3 mg (0.3 mL). • For refractory cases unresponsive to 3 IM epinephrine doses initiate epinephrine continuous infusion with an initial rate of 0.1 mcg/kg/min (infusion range of 0.1 – 1 mcg/kg/min). ☒ **DiphenhydrAMINE (Benadryl)** injection 1 mg/kg IV once as needed for anaphylaxis. Max of 50 mg. ☒ **MethylPREDNISolone (Solu-Medrol)** injection 1mg/kg IV once as needed for anaphylaxis. Max of 125 mg. ☒ **Sodium chloride 0.9%** bolus 20 mL/kg IV over one hour, once as needed for anaphylaxis.
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/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.