



**Thank you for selecting our infusion services team to care for your patient. Please provide ALL information listed below to ensure that we can process orders and schedule your patient for treatment without delay.**

**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:**

- ☐ Orders and instruction (use the PeaceHealth approved ordering form if you are not a PeaceHealth provider) are complete and include provider signature at the bottom of each 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 added phone calls, you may participate to utilize PeaceHealth preferred medication formulary options by signing this document. A clinical pharmacist will adjust orders to align with PeaceHealth medical staff approved medication formulary options, policies, and procedures.

*I agree to utilize PeaceHealth preferred medication formulary options, policies and procedures that have been authorized by PeaceHealth Medical Staff. 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 orders to: PHMC OP Infusion and Nursing Services 541-902-1649**



## Tezepelumab-EKKO (Tezspire) 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"/> <b>Tezepelumab (Tezspire) injection 210 mg</b> subcutaneous every <b>28 days</b> .
Nursing Orders	<input checked="" type="checkbox"/> Prior to administration, remove from the refrigerator and allow to reach room temperature for ~60 minutes. Do not shake or expose to heat.
Emergency Medications	<p>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</p> <p><input checked="" type="checkbox"/> <b>Standard Emergency Medications:</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> <b>Diphenhydramine (Benadryl) injection 25-50 mg IM</b> once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (<math>\geq 20</math> points in SBP), nausea, urticaria, chills, pruritic). <ul style="list-style-type: none"> <li>• Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction.</li> <li>• 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 contact provider.</li> </ul> </li> <li><input checked="" type="checkbox"/> <b>Albuterol 90 mcg/actuation inhaler</b> 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available.</li> <li><input checked="" type="checkbox"/> <b>Methylprednisolone (Solu-Medrol) injection 125 mg IM</b> 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 (<math>\geq 20</math> points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl), and contact provider. Do not inject into deltoid.</li> <li><input checked="" type="checkbox"/> <b>EPINEPHrine (Adrenalin) injection 0.5 mg IM</b> once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (<math>\geq 40</math> points in SBP), shortness of breath with wheezing and O2 Sat less than 90%), and contact provider.</li> </ul>
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<p><b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b></p> <p><b>PeaceHealth Peace Harbor Medical Center</b>  <b>Peace Harbor Hospital Outpatient Infusion Services Department</b>  400 Ninth Street  Florence, OR 97439  Contact Phone: 541-902-6019  <b>FAX 541-902-1649</b></p>
Authorization by Verbal or Telephone Order	<p>Person giving verbal or telephone order: _____</p> <p>Person receiving verbal or telephone order: _____</p> <p><input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy</p>

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

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