



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**



## Abatacept (Orencia) 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
<b>For Admission to Service</b>	<p><b>Provider Instruction</b> – Review information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> <li>1. Provider has screened patient for history of active or chronic infection, COPD, tuberculosis, hepatitis B infection, or malignancy prior to initiation of Abatacept (Orencia) therapy:</li> <li>2. <b>Date of hepatitis screening:</b> _____</li> <li>3. <b>Date of tuberculosis screening:</b> _____</li> </ol>
<b>Supportive Care</b>	<p><input checked="" type="checkbox"/> <b>Abatacept (Orencia) IV infusion in NS 100 ml infused over 30 minutes:</b></p> <p><b>Select Dose:</b></p> <p><input type="checkbox"/> 500 mg (recommended for weight less than 60 kg)</p> <p><input type="checkbox"/> 750 mg (recommended for weight 60-100 kg)</p> <p><input type="checkbox"/> 1000 mg (recommended for weight greater than 100 kg)</p> <p><b>Select Frequency:</b></p> <p><input type="checkbox"/> Initiation regimen at 0, 2 and 4 weeks followed by maintenance infusion every 4 weeks</p> <p><input type="checkbox"/> Maintenance infusion every 4 weeks</p> <p><input type="checkbox"/> Maintenance infusion every _____ weeks (indicate frequency)</p> <p><b>Additional order instruction:</b></p> <p><input checked="" type="checkbox"/> Use 0.2-1.2 micron low protein-binding in-line filter.</p>
<b>Labs</b>	<p><input type="checkbox"/> CBC with automated differential once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> Comprehensive metabolic panel once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> Must wait for lab results to start infusion, OR</p> <p><input type="checkbox"/> May proceed with infusion while waiting for lab results</p> <p><input checked="" type="checkbox"/> Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.</p>
<b>Nursing Orders</b>	<p><input checked="" type="checkbox"/> Confirm patient has negative PPD/tuberculosis and hepatitis B screenings prior to starting treatment.</p> <p><input checked="" type="checkbox"/> Assess vital signs upon arrival prior to infusion, after the start of infusion, upon discontinuation of infusion and before the patient discharges.</p> <p><input checked="" type="checkbox"/> <b>FOR INFUSION/ALLERGIC REACTION:</b> Slow or stop abatacept infusion. Flush abatacept line with normal saline before administering PRN medications. Vital signs: every 15-30 minutes as needed. If reaction resolves, then resume infusion at half the previous rate. If reaction worsens discontinue infusion, maintain IV site until vital signs and conditions become stable, notify MD.</p> <p><input checked="" type="checkbox"/> Anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, tongue swelling) and patient does not respond to diphenhydramine and/or methylprednisolone; give epinephrine, notify MD, and transfer to ED as needed.</p> <p><input checked="" type="checkbox"/> Patient may be discharged when vital signs are stable, patient does not display any evidence of adverse reaction, and infusion is complete or discontinued.</p>
<b>Nursing IV Access and Maintenance</b>	<p><b>Select the most appropriate option below:</b></p> <p><input checked="" type="checkbox"/> Insert <b>PERIPHERAL IV</b> as needed and flush (unless provider selects option for a central line).</p>

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

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



**Abatacept (Orencia)  
Outpatient Infusion Therapy Plan**

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Heading	Content
	<p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care.</p> <p><input type="checkbox"/> <b>Access and use <u>NON-PICC</u> Central Line/CVAD</b></p> <p><input checked="" type="checkbox"/> Initiate Central Line (non-PICC) maintenance protocol.</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, before and after medication administration, at discharge, and at de-access (sterile NS for Port-a-Cath access)</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw.</p> <p><input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access.</p> <p><input type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for occluded central line catheters- For clearing central line catheter. Add 2.2 mL sterile water for injection to 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. Retain in catheter for 30 minutes to 2 hours; may instill a second dose if occluded.</p> <p><input type="checkbox"/> <b>Access and use <u>PICC</u> Central Line/CVAD</b></p> <p><input checked="" type="checkbox"/> Initiate PICC maintenance protocol.</p> <p><input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed.</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, and before and after medication administration.</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw</p> <p><input type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for occluded central line catheters- For clearing central line catheter. Add 2.2 mL sterile water for injection to 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. Retain in catheter for 30 minutes to 2 hours; may instill a second dose if occluded</p>
<b>As Needed Medications</b>	<p><b>Standard As Needed Medications:</b></p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care.</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% 500 mL continuous infusion at 25 mL/hour IV as needed for therapy administration (i.e., blood products, chemotherapy, potassium administration).</p>
<b>Emergency Medications</b>	<p><b>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</b></p> <p><input checked="" type="checkbox"/> <b>Standard Emergency Medications:</b></p> <p><input checked="" type="checkbox"/> <b>DiphenhydrAMINE (Benadryl) injection</b> 25-50 mg IV once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (&gt;= 20 points in SBP), nausea, urticaria, chills, pruritic).</p> <ul style="list-style-type: none"> <li>• Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction</li> <li>• 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.</li> </ul> <p><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.</p>

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

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Patient Identification Label



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Heading	Content
	<input checked="" type="checkbox"/> <b>MethylPREDNISolone (Solu-Medrol) injection</b> 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, pruritic) that worsen or persist after administration of diphenhydramine (Benadryl) and notify provider. <input checked="" type="checkbox"/> <b>EPINEPHrine (Adrenalin) injection</b> 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 O2 Sat < 90%) and notify provider.
<b>Referral</b>	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
<b>PHMC Outpatient Infusion Contact Information</b>	<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>
<b>Authorization by Verbal or Telephone Order</b>	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

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

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