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

Epoetin alfa-epbx (RETACRIT) 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. Correct preexisting iron, B12 and/or folate deficiencies prior to therapy. 2. Provider has screened patient for uncontrolled hypertension, seizures, heart failure, coronary heart disease and stroke prior to initiating therapy. 3. Provide patient with the FDA approved medication guide for epoetin alfa-epbx (Retacrit).
Supportive Care	☒ **Goal of treatment** – Hemoglobin concentration 10 - 11 g/dL. Hemoglobin must be below 10 g/dL on initiation. **Choose one of the following (A-C):** **Initiation orders for patients with CKD not on dialysis:** ☐ Epoetin alpha-epbx (Retacrit) injection 50 **units/kg** subcutaneous every week ☐ Epoetin alpha-epbx (Retacrit) injection 100 **units/kg** subcutaneous every week ☐ Epoetin alpha-epbx (Retacrit) injection _____ **units** subcutaneous every _____ (frequency) A. **Maintenance orders to continue current dose (renewal of expired orders):** ☐ Epoetin alpha-epbx (Retacrit) injection _____ **units** subcutaneous every _____ (frequency) B. **Dose and Dose Adjustment by Provider:** ☐ Epoetin alpha-epbx (Retacrit) injection _____ **units** subcutaneous every _____ (frequency) **Additional order instruction:** ☒ Pharmacist to adjust dose as needed to maintain therapeutic goal using the epoetin alpha-epbx (Retacrit) dose adjustment guidelines. ☒ Dose of epoetin alpha-epbx (Retacrit) may be rounded to the nearest 1000 units.
Nursing Orders	☒ Hold epoetin alfa-epbx if hemoglobin is greater than 11 g/dL and notify provider. ☒ Patients receiving concurrent treatment with Iron Sucrose (Venofer) and/or Vitamin B12 cannot receive an erythropoiesis stimulating agent (e.g., Retacrit) treatment on the same day. *Since hemoglobin values increase within 2 to 4 weeks, it is recommended to wait at least 2 weeks before drawing new hemoglobin lab and administering Retacrit based on that lab result.* ☒ Measure blood pressure at each visit. Hold Retacrit and contact provider if blood pressure is greater than 160/90 mmHg.
Labs	☒ Hemoglobin and hematocrit once prior to beginning treatment and every 7 days for weekly dosing, every 14 days for every 2-week dosing, or every 28 days for every 4-week dosing. May decrease to every 4 weeks once hemoglobin is stable. ☒ Iron Deficiency Panel once prior to beginning treatment and every 84 days. ☐ BMP once prior to beginning treatment and every 7 days for weekly dosing, every 14 days for every 2-week dosing, or every 28 days for every 4-week dosing. May decrease to every 4 weeks along with CBC monitoring once hemoglobin is stable. ☐ Vitamin B12 and Folate once prior to beginning treatment and every 84 days ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.

Practitioner Signature: _____Date of Order: _____Time: _____

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

Patient Identification Label

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Heading	Content
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.