



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



Golimumab (Simponi Aria) 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	<p>Provider Instruction – Please review information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> 1. Provider has verified that patient is up to date with all immunizations prior to initiation. 2. Provider has screened patient for tuberculosis, hepatitis, chronic infection, and malignancy prior to initiation. <i>Recommend PPD or Quantiferon TB along with Hep B done within last 1-2 years.</i> <p>Date of screening (required for service): _____</p> <ol style="list-style-type: none"> 3. If patient on Methotrexate or Leflunomide, then order the following labs: CBC with auto differential and CMP. 4. Provide patient with the FDA approved medication guide for golimumab (Simponi Aria).
Pre-Medications	<p><input type="checkbox"/> Acetaminophen (Tylenol) tablet 650 mg PO once prior to infusion</p> <p><input type="checkbox"/> DiphenhydrAMINE (Benadryl) 25 mg PO once prior to infusion, OR</p> <p><input type="checkbox"/> DiphenhydrAMINE (Benadryl) 25 mg IV once prior to infusion.</p>
Supportive Care	<p><input checked="" type="checkbox"/> Golimumab (Simponi Aria) 2 mg/kg IV in NS 100 ml (total volume) over 30 minutes</p> <p>Select Frequency:</p> <p><input type="checkbox"/> Initiation regimen administered at 0 and 4 weeks followed by maintenance infusion every 8 weeks</p> <p><input type="checkbox"/> Maintenance infusion every 8 weeks</p> <p>Additional order instruction:</p> <p><input checked="" type="checkbox"/> Use an infusion set with an in-line low protein-binding 0.22 micron filter. Do not infuse in the same line with other medications.</p>
Labs	<p><input type="checkbox"/> CBC with automated differential once prior to beginning treatment and every 8 weeks</p> <p><input type="checkbox"/> Comprehensive metabolic panel once prior to beginning treatment and every 8 weeks</p> <p><input type="checkbox"/> C-reactive protein (CRP) once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> Sedimentation rate (ESR) once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> Quantiferon Gold once prior to beginning treatment and yearly</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>
Nursing Orders	<p><input checked="" type="checkbox"/> Patients should be evaluated for tuberculosis risk factors and latent tuberculosis infection (with a tuberculin skin test) prior to and during therapy.</p> <p><input checked="" type="checkbox"/> Hold golimumab infusion and notify provider for signs and symptoms of infection.</p> <p><input checked="" type="checkbox"/> Vital signs prior to infusion, every 30 minutes during infusion, and 30 minutes post-infusion. Call provider for: systolic blood pressure less than 90, pulse greater than 120, temperature greater than 38.5 degrees Celsius.</p> <p><input checked="" type="checkbox"/> If stable 30 minutes post infusion, discharge patient home on usual medications.</p>

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

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



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<p>Nursing IV Access and Maintenance</p>	<p>Select the most appropriate option below:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Insert PERIPHERAL IV once as needed <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care <input type="checkbox"/> Access and use NON-PICC Central Line/CVAD as needed and confirm patency <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Initiate Central Line (Non-PICC) maintenance protocol <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw <input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access <input type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter once as needed x 2 doses. 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, instill a second dose if occluded. <input type="checkbox"/> Access and use PICC Central Line/CVAD as needed and confirm patency <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Initiate PICC maintenance protocol <input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw <input type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter once as needed x 2 doses. For clearing central line catheter.
<p>As Needed Medications</p>	<p>Standard As Needed Medications:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Acetaminophen (Tylenol) tablet 650 mg PO once as needed for aches or temp change > 2 degrees F <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care <input checked="" type="checkbox"/> Sodium chloride 0.9% 500 mL continuous infusion at 25 mL/hour IV as needed for line care/therapy administration
<p>Emergency Medications</p>	<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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Standard Emergency Medications: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 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). <ul style="list-style-type: none"> • 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. <input checked="" type="checkbox"/> 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.

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

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	<p><input checked="" type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> 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 O2 Sat < 90%), and notify provider.</p>
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<p>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</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.