



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**



## Immune Globulin (IVIG) 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>Pre-Medications</b>                   | <input type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO once upon arrival<br><input type="checkbox"/> Diphenhydramine (Benadryl) 25 mg PO once upon arrival<br><input type="checkbox"/> Dexamethasone (Decadron) 10 mg IV once upon arrival   |
| <b>Supportive Care</b>                   | <input checked="" type="checkbox"/> <b>Immune Globulin (IVIG) IV infusion:</b><br><br><b>Indicate Brand:</b><br><input type="checkbox"/> Gamunex-C<br><input type="checkbox"/> Other (please specify): _____<br><br><b>Indicate Dose:</b> _____ (Dose will be rounded to vial size)<br><b>Indicate Frequency:</b><br><input type="checkbox"/> Once<br><input type="checkbox"/> Other (please specify): _____<br><br><b>Additional order instruction:</b><br><input checked="" type="checkbox"/> Start infusion at 0.005 mL/kg/min for 30 minutes. Rate may be doubled every 15-30 minutes as tolerated by patient. Max rate 0.08 mL/kg/min.<br><input checked="" type="checkbox"/> Immune globulin is a blood product and should not be administered with other intravenous fluids or medications.   |
| <b>Labs</b>                              | <input type="checkbox"/> BUN once prior to treatment and every _____ weeks.<br><input type="checkbox"/> CBC with Automated Differential once prior to treatment and every _____ weeks.<br><input type="checkbox"/> DAT, Polyspecific once prior to treatment.<br><input type="checkbox"/> Immunoglobulin G, Total once prior to treatment and every _____ weeks.<br><input type="checkbox"/> Creatinine once prior to treatment and every _____ weeks.<br><input type="checkbox"/> Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.  |
| <b>Nursing Orders</b>                    | <input checked="" type="checkbox"/> Check vital signs prior to administration of medication, every 15 minutes x 2, then every 30 minutes and after each increase of infusion rate, until patient is max rate and patient is stable. Then check vital signs every 1 hour until infusion is complete.  |
| <b>Nursing IV Access and Maintenance</b> | <b>Select the most appropriate option below:</b><br><input checked="" type="checkbox"/> <b>Insert PERIPHERAL IV</b> once as needed<br><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care<br><input type="checkbox"/> <b>Access and use NON-PICC Central Line/CVAD</b> as needed and confirm patency<br><input checked="" type="checkbox"/> Initiate Central Line (Non-PICC) maintenance protocol<br><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.<br><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw<br><input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access<br><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: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a 2 <sup>nd</sup> dose if occluded. |

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

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



## Immune Globulin (IVIG) 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   |
|---|---|
|   | <input type="checkbox"/> <b>Access and use PICC Central Line/CVAD</b><br><input checked="" type="checkbox"/> Initiate PICC maintenance protocol.<br><input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed.<br><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration.<br><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw.<br><input type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing occluded central line catheters. 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.   |
| <b>As Needed Medications</b>                        | <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care.<br><input checked="" type="checkbox"/> Sodium chloride 0.9% 500 mL continuous IV infusion at 25 mL/hour as needed for therapy admin.<br><input checked="" type="checkbox"/> Acetaminophen tablet 650 mg <b>PO</b> every 4 hours as needed for aches or fever, OR<br><input checked="" type="checkbox"/> Acetaminophen suppository 650 mg <b>PR</b> every 4 hours as needed for aches or fever.  |
| <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><b>Standard Emergency Medications:</b></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 (greater than or equal to 20 points in SBP), nausea, urticaria, chills, pruritis). <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> <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 notify provider. Administer with a spacer if available.<br><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 (greater than or equal to 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist after administration of diphenhydramine (Benadryl) and notify provider.<br><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 (greater than or equal to 40 points in SBP), shortness of breath with wheezing and O2 Sat less than 90%) and notify provider. |
| <b>Referral</b>                                     | <input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services   |
| <b>PHMC Outpatient Infusion Contact Information</b> | <p><b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b></p> <p><b>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department</b><br/>                     400 Ninth Street, Florence, OR 97439<br/>                     Contact Phone: 541-902-6019 and FAX <b>541-902-1649</b></p>  |
| <b>Authorization by Verbal or Telephone Order</b>   | Person giving verbal or telephone order: _____<br>Person receiving verbal or telephone order: _____<br><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.