



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**



**InFLIXimab and Biosimilars  
Outpatient Infusion Therapy Plan  
Initiation and Maintenance**

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																
<p><b>For Admission to Service</b></p>	<p><b>Provider Instruction</b> –please review and address requirements for admission to service:</p> <ol style="list-style-type: none"> <li>Ordering physician/provider has screened this patient for history of chronic infection, heart failure, seizure disorder, liver disease, tuberculosis, blood dyscrasias, hepatitis (hepatitis B surface antigen and hepatitis B core antibody), or malignancy prior to initiation of InFLIXimab (Remicade®) or biosimilar equivalent therapy. <b>Date of screening:</b> _____</li> <li>Provide patient with the FDA approved medication guide for inFLIXimab.</li> </ol>																
<p><b>Supportive Care</b></p>	<p><b>Select One:</b></p> <p><input type="checkbox"/> InFLIXimab-dyyb (Inflixtra) IV infusion (formulary preferred agent); or</p> <p><input type="checkbox"/> InFLIXimab-abda (Renflexis) IV infusion; or</p> <p><input type="checkbox"/> InFLIXimab (Remicade) IV infusion;</p> <p><b>Select Dose</b> (Dose will be rounded to nearest vial size):</p> <p><b><u>Weight-based Dose</u></b></p> <p><input type="checkbox"/> 5 mg/kg</p> <p><input type="checkbox"/> 3 mg/kg</p> <p><input type="checkbox"/> _____ mg/kg (indicate other dose)</p> <p><b><u>Non Weight-based Dose</u></b></p> <p><input type="checkbox"/> _____ mg (indicate dose)</p> <p><b>Select Frequency:</b></p> <p><b>For new patients beginning infliximab therapy:</b></p> <p><input type="checkbox"/> Initiation regimen administered at 0, 2 and 6 weeks <i>followed by</i> maintenance infusion every 8 weeks</p> <p><input type="checkbox"/> Initiation regimen administered at 0, 2 and 6 weeks <i>followed by</i> maintenance infusion every ___ weeks</p> <p><b>For established patients on maintenance therapy:</b></p> <p><input type="checkbox"/> Maintenance infusion every 8 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 an in-line, sterile, non-pyrogenic, low protein-binding filter with 1.2-micron pore size or less.</p> <p><input checked="" type="checkbox"/> Begin inFLIXimab infusion at 10 mL/hr and increase rate per the following schedule:</p> <table border="1" data-bbox="483 1367 1144 1711"> <thead> <tr> <th colspan="2">INFUSION RATE SCHEDULE</th> </tr> <tr> <th>Time (minutes)</th> <th>Infusion Rate</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Initiate at 10 mL/hr x 15 min</td> </tr> <tr> <td>15</td> <td>Increase to 20 mL/hr x 15 min</td> </tr> <tr> <td>30</td> <td>Increase to 40 mL/hr x 15 min</td> </tr> <tr> <td>45</td> <td>Increase to 80 mL/hr x 15 min</td> </tr> <tr> <td>60</td> <td>Increase to 150 mL/hr x 15 min</td> </tr> <tr> <td>90</td> <td>Increase to 250 mL/hr until done</td> </tr> </tbody> </table>	INFUSION RATE SCHEDULE		Time (minutes)	Infusion Rate	0	Initiate at 10 mL/hr x 15 min	15	Increase to 20 mL/hr x 15 min	30	Increase to 40 mL/hr x 15 min	45	Increase to 80 mL/hr x 15 min	60	Increase to 150 mL/hr x 15 min	90	Increase to 250 mL/hr until done
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Patient Identification Label



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<p><b>Nursing Orders</b></p>	<p><input checked="" type="checkbox"/> For new patients beginning infliximab therapy:</p> <ul style="list-style-type: none"> <li>• Prior to starting inFLIXimab therapy ensure patient has had a recent PPD. If positive PPD and patient has not received isoniazid therapy, consult with physician regarding initiation of isoniazid therapy.</li> <li>• Infusions #1-4: Vitals prior to infusion, before each rate increase, 30 minutes following infusion. Observe patient 30 minutes after completion of infusion.</li> </ul> <p><input checked="" type="checkbox"/> For ongoing maintenance therapy:</p> <ul style="list-style-type: none"> <li>• Infusion # 5-8: vitals prior to infusion, 30 minutes after initiation, at end of infusion, and 30 minutes following infusion. Observe patient 30 minutes after completion of infusion.</li> <li>• Infusion #9: vitals prior to infusion, at end of infusion, and 30 minutes following infusion. Observe patient 30 minutes after completion of infusion.</li> <li>• Infusion #10 &amp; beyond: vitals prior to infusion and end of infusion. No observation required upon completion of infusion.,</li> </ul>
<p><b>Labs</b></p>	<p><input checked="" type="checkbox"/> CBC with automated differential once prior to starting treatment.</p> <p><input type="checkbox"/> CBC with automated differential every _____ weeks</p> <p><input checked="" type="checkbox"/> Comprehensive metabolic panel once prior to starting treatment.</p> <p><input type="checkbox"/> Comprehensive metabolic panel every _____ weeks</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>
<p><b>Nursing IV Access and Maintenance</b></p>	<p><b>Select the most appropriate option below:</b></p> <p><input checked="" type="checkbox"/> <b>Insert PERIPHERAL IV</b> as needed and flush (unless provider selects option for a central line).</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care.</li> </ul> <p><input type="checkbox"/> <b>Access and use NON-PICC Central Line/CVAD</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Initiate Central Line (non-PICC) maintenance protocol.</li> <li><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)</li> <li><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw.</li> <li><input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access.</li> <li><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. Instill medication in non-functional lumen. Do not use lumen while dwelling. Allow to dwell 30 minutes and check for patency by drawing back on lumen for blood return. If line is still not patent, allow medication to dwell an additional 90 minutes. Dwell time not to exceed 120 min. Use second dose of Alteplase (Cathflo) if catheter is not patent after 120 min. If the catheter is functional, aspirate and waste the medication and residual clot prior to flushing the line.</li> </ul> <p><input type="checkbox"/> <b>Access and use PICC Central Line/CVAD</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Initiate PICC maintenance protocol.</li> <li><input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed.</li> <li><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, and before and after medication administration.</li> </ul>

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<b>As Needed Medications</b>	<b>Standard As Needed Medications:</b> <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 therapy administration (i.e., blood products, chemotherapy, potassium administration).
<b>Pre-Medications</b>	<input type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO once on arrival <input type="checkbox"/> DiphenhydrAMINE (Benadryl) 25 mg PO once on arrival, <b>OR</b> <input type="checkbox"/> Loratadine (Claritin) 10 mg PO once on arrival <input type="checkbox"/> MethylPREDNISolone sodium succinate (Solu-MEDROL) 40 mg IV once on arrival
<b>Emergency Medications</b>	<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> <b>Standard Emergency Medications:</b> <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 ( $\geq$ 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 contact provider.</li> </ul> <input 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. <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 ( $\geq$ 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl) and contact 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 ( $\geq$ 40 points in SBP), shortness of breath with wheezing and O2 Sat < 90% and contact provider.
<b>Referral</b>	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services

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<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</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

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