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

Ustekinumab (Stelara)
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. Order one CBC with differential, CMP, CRP, ESR, and tuberculosis screening test prior to patient starting treatment. **Date of screening (required for service)**: _____ 2. Provide patient with the FDA approved medication guide for ustekinumab (Stelara).
Labs	☐ CBC with automated differential once prior to treatment ☐ Comprehensive metabolic panel once prior to treatment ☐ C-reactive protein (CRP) once prior to treatment ☐ Sedimentation rate (ESR) once prior to treatment ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
Pre-Medications	☐ Acetaminophen (Tylenol) 650 mg PO once ☐ DiphenhydrAMINE (Benadryl) 25 mg PO once (may use IV or PO) ☐ DiphenhydrAMINE (Benadryl) 25 mg IV once (may use IV or PO)
Supportive Care	☒ **Ustekinumab (Stelara)** IV infusion in NS 250 ml infused over 60 minutes: **Select Dose:** ☐ 260 mg (weight ≤ 55 kg) once ☐ 390 mg (weight 56-85 kg) once ☐ 520 mg (weight > 85 kg) once **Additional order instruction:** ☒ Infuse through 0.2 micron low-protein binding filter. Do not infuse concomitantly in the same IV line with other agents.
Nursing Orders	☒ Assess vital signs prior to infusion, every 30 minutes during infusion, and 30 minutes post infusion. Call provider for systolic blood pressure < 80 or > 200 mmHg, pulse < 50 or > 130 bpm, or temperature > 38.3 °C. If stable 30 minutes post infusion, discharge patient home on usual home medication. ☒ Future subcutaneous doses of Ustekinumab are no longer covered in the infusion center population, this is considered a self-administered medication.
Nursing IV Access and Maintenance	**Select the most appropriate option below:** ☒ **Insert PERIPHERAL IV** once as needed ☒ Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care ☐ **Access and use NON-PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate Central Line (Non-PICC) maintenance protocol ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care prior to and post medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access

Practitioner Signature: _____Date of Order: _____Time: _____

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

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Ustekinumab (Stelara)
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
	☒ Alteplase (Cathflo) injection 2 mg intra-catheter once as needed for line care x 2 doses. Reconstitute with 2.2 mL sterile water to the 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. 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 minutes. Use second dose of Alteplase (Cathflo) if catheter not patent after 120 minutes. If the catheter is functional, aspirate and waste the medication and residual clot prior to flushing the line. ☐ **Access and use PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate PICC maintenance protocol ☒ Change PICC line dressing weekly and as needed ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care prior to and post medication administration ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Alteplase (Cathflo) injection 2 mg intra-catheter once as needed for line care x 2 doses
As Needed Medications	☒ Acetaminophen (Tylenol) 650 mg PO every 4 hours as needed for mild pain, fever ☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care ☒ Sodium chloride 0.9% 500 mL continuous infusion IV once as needed at 25 mL/hour for line care
Emergency Medications	**If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.** ☒ **Standard Emergency Medications:** ☒ **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 (greater than or equal to 20 points in SBP), nausea, urticaria, chills, pruritis). • 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. ☒ **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. ☒ **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 (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. ☒ **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 (greater than or equal to 40 points in SBP), shortness of breath with wheezing and 0^2 Sat less than 90%) and notify provider.

Practitioner Signature: _____Date of Order: _____Time: _____

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

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Ustekinumab (Stelara)
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
Referral	☒ Ambulatory referral to OP Infusion Services
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.