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. Please provide ALL information listed below to ensure that we can process orders and schedule your patient for treatment without delay.

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:

☐ Orders and instruction (use the PeaceHealth approved ordering form if you are not a PeaceHealth provider) are complete and include provider signature at the bottom of each 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 added phone calls, you may participate to utilize PeaceHealth preferred medication formulary options by signing this document. A clinical pharmacist will adjust orders to align with PeaceHealth medical staff approved medication formulary options, policies, and procedures.

I agree to utilize PeaceHealth preferred medication formulary options, policies and procedures that have been authorized by PeaceHealth Medical Staff. 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 orders to: PHMC OP Infusion and Nursing Services 541-902-1649

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Denosumab (JUBBONTI) or Biosimilar 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 –** Review the information below and address requirements for admission to service: 1. If patient is new to denosumab therapy, must have baseline labs completed prior to treatment. For subsequent treatment, use corrected calcium within predetermined timeframe before treatment. Select timeframe within nursing communication orders. • **WITHIN 7 MONTHS**- May be appropriate for individuals who do not have impaired renal function or elevated risk for hypocalcemia (i.e., eGFR of 60 or higher), no history of malabsorptive conditions or malabsorptive procedures such as gastric bypass, or history of hypoparathyroidism) and who are regularly obtaining stable intake of calcium and vitamin D. • **WITHIN 3 MONTHS**- May be appropriate for individuals who have mild-to-moderate impairment in renal function (eGFR 45-59) or history of malabsorption but with stable supplementation and nutrition. • **WITHIN 1 MONTH**- May be appropriate for individuals who have impaired renal function (eGFR of less than 45) or concerns about elevated risk for hypocalcemia (known issues with nutrition or intestinal absorption), or who may be at elevated risk for progression in renal impairment which would also increase risk of severe hypocalcemia due to denosumab treatment. More frequent monitoring of calcium may be needed for individuals with more advanced CKD. For individual with eGFR less than 15, denosumab should be introduced only with caution due to risk of hypocalcemia, and ideally under the guidance of a specialist in metabolic bone disease/osteoporosis. 2. Ensure adequate calcium and vitamin D intake to prevent or treat hypocalcemia. Calcium 1000 mg/day and vitamin D equal to or greater than 400 units/day is recommended in product labeling (Prolia). 3. Remind patient of importance of good dental hygiene and ensure patient has had a satisfactory dental exam prior to start of therapy. 4. Review FDA Risk Evaluation and Mitigation Strategies for PROLIA and provide patient with a paper copy of the required education.
Supportive Care	**Treatment of osteoporosis and/or bone loss:** ☒ Denosumab-bbdz (JUBBONTI) 60 mg injection subcutaneously every 6 months ☐ Denosumab (PROLIA) 60 mg injection subcutaneously every 6 months
Labs	**Selection required** choose timeframe to be drawn: ☐ Baseline CMP prior to initiation and within **1 month** prior to dose for ongoing therapy ☐ Baseline CMP prior to initiation and within **3 months** prior to dose for ongoing therapy ☐ Baseline CMP prior to initiation and within **7 months** prior to dose for ongoing therapy ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post planned treatment date.

Practitioner Signature: _____Date of Order: _____Time: _____

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

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Heading	Content
Nursing Orders	☒ Provide patient with the *FDA approved medication guide* for Prolia. ☒ Nursing communication – Instruct patient to take calcium 1000 mg daily and at least 400 IU vitamin D daily. ☒ Nursing communication – Remind patient of good dental hygiene and to avoid dental procedures other than cleaning. ☒ Nursing communication – If patient is new to therapy, must have baseline labs completed prior to treatment. If corrected calcium is normal within specified time frame, no need to wait to proceed with treatment. If last calcium lab was not within the specified timeframe, draw calcium and albumin (CMP), wait for results prior to administration of denosumab. Notify provider if corrected calcium is less than 8.5.
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 IM 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, pruritic). • Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction • Administer 25 mg IM if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IM dose for a total of 50 mg and contact provider. ☐ **Albuterol 90 mcg/actuation inhaler** 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available. ☒ **MethylPREDNISolone (Solu-Medrol) injection** 125 mg IM 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, pruritic) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl) and contact provider. **Do not inject into deltoid**. ☒ **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 02 Sat less than 90% and contact provider.
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***
Verbal or Telephone Authorization	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.