



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



Denosumab (XGEVA) 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- <ol style="list-style-type: none"> 1. Provider to order CMP prior to patient beginning treatment. 2. Correct preexisting hypocalcemia and vitamin D deficiency prior to treatment. 3. Monitor calcium levels throughout Xgeva therapy, especially in the first few weeks of initiating therapy. 4. Ensure adequate calcium and vitamin D intake to prevent or treat hypocalcemia associated with denosumab. Calcium 1000 mg/day and vitamin D \geq 400 units/day is recommended in product labeling if dietary intake is inadequate. 5. Remind patient of importance of good dental hygiene and regular dental exams due to the risk of osteonecrosis of the jaw. Avoid invasive dental procedures if possible. 6. Remind patient of importance of remaining on schedule with injections. If stopped, skipped, or delayed the risk for fracture increases.
Supportive Care	<input checked="" type="checkbox"/> Denosumab (Xgeva) 120 mg injection subcutaneously every 28 days.
Nursing Orders	<input checked="" type="checkbox"/> Use corrected calcium drawn within last 30 days for Xgeva. If previous corrected calcium (within last 30 days) was less than 8.5, wait for calcium results. If previous corrected calcium (within last 30 days) is less than 8.5, and if calcium still below 8.5 on same day draw, hold treatment, and contact provider. If patient's last calcium draw was greater than 30 days, re-draw calcium and wait for results. <input checked="" type="checkbox"/> Remind patient of good dental hygiene and to avoid dental procedures other than cleaning.
Labs	<input checked="" type="checkbox"/> CMP within 30 days prior to each treatment. <input checked="" type="checkbox"/> CMP redraw as needed per nursing order for hypocalcemia <input type="checkbox"/> Magnesium level _____ (specify frequency) <input type="checkbox"/> Phosphorous level _____ (specify frequency) <input checked="" type="checkbox"/> Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
Emergency Medications	<input checked="" type="checkbox"/> Standard Emergency Medications: <input checked="" type="checkbox"/> 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 (\geq 20 points in SBP), nausea, urticaria, chills, pruritic). <ul style="list-style-type: none"> • 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. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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 (\geq 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.

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

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

PRGORD

Progress & Orders



Patient Identification Label

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Heading	Content
	<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 less than 90% and contact provider.
Referral	<input checked="" type="checkbox"/> 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: _____ <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.