



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



Anticoagulation Bridging with Enoxaparin 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 | <p>Surgeon and Provider Instruction – Review information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> 1. Surgeon to consult patient cardiologist or primary care provider as needed to determine anticoagulation bridging requirement. 2. Surgeon to contact PHMG Anticoagulation Clinic (ACC) to initiate anticoagulation bridging process. Send notification of bridging requirement and date of procedure to: Anticoagulation Clinic, 380 Ninth Street, Florence OR 97439, FAX 541-902-1612, Phone 541-997-1335. 3. Surgeon or provider order CBC (no differential) and CMP prior to patient beginning treatment. 4. Surgeon or provider to screen patient for contraindications and potential adverse events (e.g., history of HIT, bleeding, thromboembolic risk, or other drug-disease risk factors). <hr/> <p>Florence PHMG Anticoagulation Clinic Nurse Instruction-</p> <ol style="list-style-type: none"> 1. ACC Nurse to receive notification to initiate anticoagulation bridging process from surgeon. 2. ACC Nurse is the point of contact in coordinating bridging therapy between surgeon, PCP, Infusion Services nurse and pharmacist, and the patient. 3. ACC Nurse to provide patient with education to the bridging process and instruct patient to stop taking warfarin according to orders (e.g., six days prior to scheduled procedure if the standard five-day bridging method is selected). | | | | | | | | | | | | | | | | | | | | | | | | |
| Admit to Service and Follow-up | <p><input checked="" type="checkbox"/> Identify procedure: _____ (required for order)</p> <p><input checked="" type="checkbox"/> Date of procedure: _____ (required for order)</p> <p><input checked="" type="checkbox"/> Follow-up anticoagulation provided by: _____ (required for order)</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre-Procedure Instruction for Bridging Off Oral Anticoagulation using Enoxaparin | <p>Provider to Choose Only One Anticoagulation Bridging Option Below (Option 1, 2 or 3):</p> <p><input type="checkbox"/> OPTION 1: FIVE-day warfarin hold prior to surgery (most common option) and anticoagulation bridging with enoxaparin per pharmacist:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width: 20%;">Date</th> <th style="width: 50%;">Bridging Instructions</th> <th style="width: 30%;">Notes</th> </tr> </thead> <tbody> <tr> <td>6 days prior to procedure</td> <td>Last dose of warfarin</td> <td><i>Date?</i></td> </tr> <tr> <td>5 days prior to procedure</td> <td>Enoxaparin bridging</td> <td></td> </tr> <tr> <td>4 days prior to procedure</td> <td>Enoxaparin bridging</td> <td></td> </tr> <tr> <td>3 days prior to procedure</td> <td>Enoxaparin bridging</td> <td></td> </tr> <tr> <td>2 days prior to procedure</td> <td>Enoxaparin bridging</td> <td></td> </tr> <tr> <td>1 day prior to procedure</td> <td>Enoxaparin bridging. Vitamin K? (See below)</td> <td></td> </tr> <tr> <td>Date of Procedure is day Zero</td> <td></td> <td><i>Date?</i></td> </tr> </tbody> </table> <p><input type="checkbox"/> OPTION 2: Anticoagulation bridging with enoxaparin per pharmacist (other than a 5-day hold):</p> <ul style="list-style-type: none"> - Date for last dose of warfarin: _____ - Begin enoxaparin bridging the following day (day after last dose of warfarin) and continue up until date of procedure. <p><input type="checkbox"/> OPTION 3: Other instruction for bridging with enoxaparin:</p> <ul style="list-style-type: none"> - Date for last dose of _____ (Specify, e.g., Apixaban): _____ - Bridging instruction: _____ | Date | Bridging Instructions | Notes | 6 days prior to procedure | Last dose of warfarin | <i>Date?</i> | 5 days prior to procedure | Enoxaparin bridging | | 4 days prior to procedure | Enoxaparin bridging | | 3 days prior to procedure | Enoxaparin bridging | | 2 days prior to procedure | Enoxaparin bridging | | 1 day prior to procedure | Enoxaparin bridging. Vitamin K? (See below) | | Date of Procedure is day Zero | | <i>Date?</i> |
| Date | Bridging Instructions | Notes | | | | | | | | | | | | | | | | | | | | | | | |
| 6 days prior to procedure | Last dose of warfarin | <i>Date?</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 5 days prior to procedure | Enoxaparin bridging | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 days prior to procedure | Enoxaparin bridging | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 days prior to procedure | Enoxaparin bridging | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 days prior to procedure | Enoxaparin bridging | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 day prior to procedure | Enoxaparin bridging. Vitamin K? (See below) | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Procedure is day Zero | | <i>Date?</i> | | | | | | | | | | | | | | | | | | | | | | | |
| Post-Procedure Instruction for Bridging Back on to Warfarin Using Enoxaparin | <p><input checked="" type="checkbox"/> INDICATION FOR ANTICOAGULATION: _____ (required for order)</p> <p><input checked="" type="checkbox"/> Target INR (2-3 or 2.5-3.5): _____ (required for order)</p> <p>Provider to choose ONE of the following:</p> <p><input checked="" type="checkbox"/> Start warfarin plus enoxaparin bridging per pharmacist the day after procedure (most common); OR, start warfarin plus enoxaparin bridging per pharmacist on _____ (date).</p> | | | | | | | | | | | | | | | | | | | | | | | | |

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

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

Patient Identification Label



Anticoagulation Bridging with Enoxaparin 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 |
|---|--|
| Enoxaparin Orders | <input checked="" type="checkbox"/> Pre-Procedure – Enoxaparin 1.5 mg/kg (total body weight) subcutaneous daily as needed for INR less than or equal to 2.0 for target INR of 2-3 OR less than or equal to 2.5 for target INR of 2.5-3.5. <input checked="" type="checkbox"/> On the day prior to procedure – Enoxaparin 0.75 mg/kg (total body weight) subcutaneous once as needed for INR less than or equal to 2.0 for target INR of 2-3 OR less than or equal to 2.5 for target INR of 2.5-3.5. <input checked="" type="checkbox"/> Post-Procedure – Enoxaparin injection 1.5 mg/kg (total body weight) subcutaneous daily until target INR is reached and maintained for at least 2 consecutive days. <input checked="" type="checkbox"/> Pharmacist to adjust dose for renal function. |
| Vitamin K Orders | <input checked="" type="checkbox"/> Phytonadione (Vitamin K) 2.5 mg PO once for INR greater than 2.0 on the day prior to procedure. Call physician performing procedure to confirm that procedure will not be delayed due to high INR. |
| Labs | <input checked="" type="checkbox"/> CBC, no differential, once prior to beginning treatment and every 3 days while using enoxaparin <input checked="" type="checkbox"/> CMP once prior to beginning treatment <input checked="" type="checkbox"/> POC INR every visit |
| Nursing Orders | <input checked="" type="checkbox"/> Obtain and record patient height and weight. <input checked="" type="checkbox"/> Review orders and instructions with patient and confirm date of last dose of warfarin. <ul style="list-style-type: none"> – Instructions for target INR range of 2-3: Pre-Procedure – Check INR daily. Administer enoxaparin for INR less than or equal to 2.0. HOLD if INR greater than 2.0. Administer Vitamin K on the day prior to procedure if needed according to orders. Post-Procedure – Check INR daily. Administer enoxaparin until target INR is reached and maintained for at least 2 consecutive days. – Instructions for target INR range of 2.5-3.5: Pre-Procedure – Check INR daily. Administer enoxaparin for INR less than or equal to 2.5. HOLD if INR greater than 2.5. Administer Vitamin K on the day prior to procedure if needed according to orders. Post-Procedure – Check INR daily. Administer enoxaparin until target INR is reached and maintained for at least 2 consecutive days. <input checked="" type="checkbox"/> Assess for signs of bleeding/clotting each visit and notify ordering provider with any concern. <input checked="" type="checkbox"/> Advise patient to contact the anticoagulation clinic to schedule an appointment. <input checked="" type="checkbox"/> Notify the PHMG anticoagulation clinic nursing pool (@.anticoagflorence) with a message in CareConnect when therapy is complete for ongoing anticoagulation services when indicated. <input checked="" type="checkbox"/> Send notice at completion of therapy to alternate service for ongoing anticoagulation follow up when indicated: _____ (Service) _____ (Contact Information) |
| Referral | <input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services |
| Provider Contact | Provider office/location: _____ Telephone: _____ FAX: _____ Email: _____ <input type="checkbox"/> Check if preferred means of contact. |
| 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.