



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



InFLIXimab and Biosimilars 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>Provider Instruction – Review information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> 1. Provider has screened 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 therapy. 2. Provide patient with FDA approved inFLIXimab medication guide. 																
Labs	<p><input type="checkbox"/> CBC with automated differential once prior to starting treatment and every _____ weeks</p> <p><input type="checkbox"/> Comprehensive metabolic panel once prior to starting treatment and 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>																
Pre-Medications	<p><input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO once prior to infusion</p> <p><input checked="" type="checkbox"/> Loratadine (Claritin) 10 mg PO once prior to infusion</p> <p><input type="checkbox"/> MethylPREDNISolone sodium succinate (Solu-MEDROL) 40 mg IV once prior to infusion</p>																
Supportive Care	<p>Select Drug:</p> <p><i>PeaceHealth Preferred</i></p> <p><input type="checkbox"/> InFLIXimab-axxq (Avsola) IV infusion</p> <p>Alternate Option:</p> <p><input type="checkbox"/> InFLIXimab-abda (Renflexis) IV infusion</p> <p><input type="checkbox"/> InFLIXimab-dyyb (Inflectra) IV infusion</p> <p><input checked="" type="checkbox"/> Use sterile, non-pyrogenic, 1.2-micron (or less) low-protein binding in-line filter.</p> <p>Select Dose (Dosing will be rounded to nearest vial size):</p> <p><input type="checkbox"/> 5 mg/kg</p> <p><input type="checkbox"/> 3 mg/kg</p> <p><input type="checkbox"/> _____ (indicate dose)</p> <p>Select Frequency:</p> <p>For new patients beginning inFLIXimab therapy:</p> <p><input type="checkbox"/> Initiation regimen given at 0, 2 and 6 weeks <i>followed by</i> maintenance infusion every 8 weeks</p> <p><input type="checkbox"/> Initiation regimen given at 0, 2 and 6 weeks <i>followed by</i> maintenance infusion every _____ weeks</p> <p>For established patients on maintenance therapy:</p> <p><input type="checkbox"/> Maintenance infusion every 8 weeks</p> <p><input type="checkbox"/> Maintenance infusion every _____ weeks (indicate frequency)</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <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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Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

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



InFLIXimab and Biosimilars Outpatient Infusion Therapy Plan

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<p>Nursing Communication</p>	<p><input checked="" type="checkbox"/> For new patients beginning inFLIXimab therapy:</p> <ul style="list-style-type: none"> • 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. • Infusion # 1-4: Vitals prior to infusion, before each rate increase, 30 minutes following infusion. Observe patient 30 minutes after completion of infusion. <p><input checked="" type="checkbox"/> For ongoing maintenance therapy:</p> <ul style="list-style-type: none"> • 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. • Infusion # 9: Vitals prior to infusion, at end of infusion, and 30 minutes following infusion. Observe patient 30 minutes after completion of infusion. • Infusion # 10 and beyond: Vitals prior to infusion and end of infusion. No observation required upon completion of infusion.
<p>Nursing IV Access and Maintenance</p>	<p>Select the most appropriate option below:</p> <p><input checked="" type="checkbox"/> Insert PERIPHERAL IV once as needed</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care <p><input type="checkbox"/> Access and use NON-PICC Central Line/CVAD as needed and confirm patency</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Initiate Central Line (Non-PICC) maintenance protocol <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw <input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access <input checked="" type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter. Reconstitute with 2.2 mL sterile water for injection 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 line. <p><input type="checkbox"/> Access and use PICC Central Line/CVAD as needed and confirm patency</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Initiate PICC maintenance protocol <input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw <input checked="" type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter

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

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InFLIXimab and Biosimilars Outpatient Infusion Therapy Plan

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As Needed Medications	<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 line care (TKO for therapy administration)
Emergency Medications	<p>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</p> <p>Standard Emergency Medications:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 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 points in SBP), nausea, urticaria, chills, pruritis) <ul style="list-style-type: none"> • 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. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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. <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 (greater than or equal to 40 points in SBP), shortness of breath with wheezing and oxygen Sat less than 90%) and notify provider.
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<p>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</p> <p>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</p>
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:** _____

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