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

PRGORD Progress & Orders

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Epoetin alfa-epbx (Retacrit) 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 information below and address requirements for admission to service: 1. Correct preexisting iron, B12 and/or folate deficiencies prior to therapy. a. If patient is receiving IV iron and/or vitamin B12 for treatment of iron/B12 deficiency, deficiencies must be resolved PRIOR to administration of erythropoiesis stimulating agent (ESA) treatment. b. Internal providers – Remove resolved problems from the problem list prior to ordering ESA. 2. Medication code Z79.899 should be used for monitoring labs. 3. Provide patient with the FDA approved medication guide for epoetin alfa-epbx (Retacrit).
Supportive Care	☒ **Goal of treatment** – Hemoglobin of 10-11 g/dL. Hemoglobin must be below 10 g/dL on initiation. A. **Initiation orders for patients with CKD not on dialysis:** ☐ Epoetin alfa-epbx (Retacrit) injection 50 **units/kg** subcutaneous every week ☐ Epoetin alfa-epbx (Retacrit) injection 100 **units/kg** subcutaneous every week ☐ Epoetin alfa-epbx (Retacrit) injection _____ **units** subcutaneous every _____ week(s) B. **Maintenance orders to continue current dose (renewal of expired orders):** ☐ Continue epoetin alfa-epbx (Retacrit) subcutaneous injection at current dose C. **Dose and Dose Adjustment by Provider:** ☐ Epoetin alfa-epbx (Retacrit) injection _____ **units** subcutaneous every _____ week(s) **Additional order instruction:** ☒ Pharmacist to adjust dose as needed to maintain therapeutic goal using the epoetin alfa-epbx (Retacrit) dose adjustment guidelines. ☒ Dose of epoetin alfa-epbx (Retacrit) may be rounded to the nearest 1000 units.
Nursing Orders	☒ Hold and contact provider if hemoglobin is greater than 11 g/dL. ☒ Patients receiving concurrent treatment with IV iron and/or vitamin B12 cannot receive ESA treatment until associated diagnoses have been resolved and removed from the problem list. ☒ Notify provider if blood pressure is greater than 160/90 mmHg.
Labs	☒ Hemoglobin and hematocrit once prior to beginning treatment and every 7 days for weekly dosing, every 14 days for every 2-week dosing, or every 28 days for every 4-week dosing. May decrease to every 4 weeks once hemoglobin is stable. ☐ Iron Deficiency Panel once prior to beginning treatment and every 84 days. ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
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.