



**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**



## Tocilizumab 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>For Admission to Service</b>          | <p><b>Provider Instruction</b> – Review information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> <li>Order one CBC with differential and CMP prior to beginning treatment.</li> <li>Ordering provider has screened this patient for history of chronic infection, active (including localized) infection, heart failure, liver disease, tuberculosis, blood dyscrasias, hepatitis (hepatitis B surface antigen and hepatitis B core antibody), or malignancy prior to initiation of tocilizumab therapy.</li> <li>It is recommended that tocilizumab not be initiated in patients with an ANC less than 2000/mm<sup>3</sup>, platelet count below 100,000/mm<sup>3</sup>, or who have ALT or AST greater than 1.5x the upper limit of normal.</li> <li>Patients should have regular monitoring for tuberculosis, infection, malignancy, neutropenia (ANC), thrombocytopenia, elevated lipids, and liver abnormalities throughout therapy. Hold treatment if a patient develops a serious infection, an opportunistic infection, or sepsis.</li> <li>Provide patient with the FDA approved medication guide for tocilizumab.</li> </ol> |
| <b>Supportive Care</b>                   | <p><b>Select Drug:</b></p> <p><b>PeaceHealth Preferred</b></p> <p><input type="checkbox"/> Tocilizumab-aazg (Tyenne) IV infused over 60 minutes</p> <p><b>Alternate Option:</b></p> <p><input type="checkbox"/> Tocilizumab-anoh (Avtozma) IV infused over 60 minutes</p> <p><input type="checkbox"/> Tocilizumab-bavi (Tofidence) IV infused over 60 minutes</p> <p><input type="checkbox"/> Tocilizumab (Actemra) IV infused over 60 minutes</p> <p><b>Select Dose:</b></p> <p><input type="checkbox"/> 4 mg/kg every 4 weeks</p> <p><input type="checkbox"/> 8 mg/kg every 4 weeks</p> <p><b>Additional order instruction:</b></p> <p><input checked="" type="checkbox"/> Doses exceeding 800 mg are NOT recommended.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Labs</b>                              | <p><input type="checkbox"/> CBC with automated differential once prior to treatment and every _____ weeks</p> <p><input type="checkbox"/> Comprehensive metabolic panel once prior to 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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Nursing IV Access and Maintenance</b> | <p><input checked="" type="checkbox"/> <b>Insert PERIPHERAL IV</b> as needed</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care</p> <p><input type="checkbox"/> <b>Access and use NON-PICC Central Line/CVAD</b> as needed and confirm patency</p> <p><input checked="" type="checkbox"/> Initiate Central Line (Non-PICC) maintenance protocol</p> <p><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</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw</p> <p><input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access</p>                                                                                                                                                                                                                                                                                                         |

**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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



## Tocilizumab and Biosimilars Outpatient Infusion Therapy Plan

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| Heading                                      | Content                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                              | <p><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> <p><input type="checkbox"/> Access and use <u>PICC Central Line/CVAD</u> as needed and confirm patency</p> <p><input checked="" type="checkbox"/> Initiate PICC maintenance protocol</p> <p><input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed</p> <p><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</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw</p> <p><input checked="" type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter</p>                                                                                                                       |
| As Needed Medications                        | <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care</p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% 500 mL continuous IV infusion at 25 mL/hour as needed for line care (TKO for therapy administration)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Emergency Medications                        | <p><input checked="" type="checkbox"/> <b>DiphenhydrAMINE (Benadryl)</b> 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 (<math>\geq 20</math> points in SBP), nausea, urticaria, chills, pruritis).</p> <ul style="list-style-type: none"> <li>Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction.</li> <li>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.</li> </ul> <p><input type="checkbox"/> <b>Albuterol 90 mcg/actuation</b> inhaler 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and notify provider. Administer with a spacer if available.</p> <p><input checked="" type="checkbox"/> <b>MethylPREDNISolone (Solu-Medrol)</b> 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 (<math>\geq 20</math> points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist after administration of diphenhydramine (Benadryl) and notify provider.</p> <p><input checked="" type="checkbox"/> <b>EPINEPHrine (Adrenalin)</b> injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (<math>\geq 40</math> points in SBP), shortness of breath with wheezing and O2 Sat <math>&lt; 90\%</math>) and notify provider.</p> |
| Referral                                     | <input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PHMC Outpatient Infusion Contact Information | <p><b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b></p> <p><b>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department</b><br/> 400 Ninth Street, Florence, OR 97439<br/> Contact Phone: 541-902-6019 and FAX <b>541-902-1649</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Authorization by Verbal or Telephone Order   | <p>Person giving verbal or telephone order: _____</p> <p>Person receiving verbal or telephone order: _____</p> <p><input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

Practitioner Signature: \_\_\_\_\_ Date of Order: \_\_\_\_\_ Time: \_\_\_\_\_

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