**PATIENT INFORMATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Desired Treatment Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: Weight(kg): Pt Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis (select one):**

* D59.5 Paroxysmal Nocturnal Hemoglobinuria
* D59.3 Atypical Hemolytic Uremic Syndrome
* Other: Clinical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication/Nursing Care Orders (select all that apply):**

* Eculizumab (Soliris) IV, diluted in Sodium Chloride 0.9% to a 5mg/mL concentration infused over a minimum of 35 minutes.
* Dosing/Frequency for PNH:
	+ Induction: 600mg once weekly Weeks 1-4, followed by 900mg once weekly Week 5
	+ Maintenance: 900 mg once every 2 weeks
* Dosing/Frequency for aHUS:
	+ Induction: 900 mg once weekly Weeks 1-4, followed by 1200 mg once weekly Week 5
	+ Maintenance: 1200 mg once every 2 weeks
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_ Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Order Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PICC line in place (If marked, please include insertion documentation)
* PICC line dressing change weekly on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Remove PICC on the last day of treatment? Yes No

**Pre-Treatment Medications to be administered 30 minutes prior to treatment (Check/Complete all that apply):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Acetaminophen
 | * 500mg
 | * 650mg
 | * 1000mg
 | * PO
 |
| * Diphenhydramine
 | * 25mg
 | * 50mg
 | * PO
 | * IV
 |
| * Methylprednisolone
 | * 40mg
 | * 125mg
 | * IV
 |  |
| * Famotidine
 | * 20mg
 | * PO
 | * IV
 |  |
| * Other:
 |

**Pre-Treatment Requirements (Check if completed. Provide supporting documentation if outside of Billings Clinic Provider Group):**

* Meningococcal vaccination administration (at least two weeks prior to start of therapy)

**Standing Orders:**

* Reaction management protocol initiation for hypersensitivity/ anaphylactic reaction.

BBC Emergent Management of Anaphylaxis in Adults #PHY037 version 05/15/21

* Patient will be monitored for 1 hour post-infusion

**Laboratory Orders (Check all that apply);**

* Complete Blood Count (CBC) with differential Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lactic Dehydrogenase (LDH) Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Serum Creatinine Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* AST Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Urinalysis Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Orders/Plan of Care Instructions:**

|  |
| --- |
|  |
|  |

**PROVIDER INFORMATION**

Referring Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Fax completed treatment plan to:** **Beartooth Billings Clinic Outpatient Services** **Fax:406-815-6667** **Phone: 406-446-0563 or 406-446-0565****IF OUTSIDE OF BILLINGS CLINIC PROVIDER GROUP:****Please include patient demographics/insurance information, current medication list, lab/test results as applicable and most recent provider documentation related to prescribed treatment plan.**  |

* Our team will confirm receipt of referral to the contact listed above.
* Treatment documentation will be viewable in Cerner if within Billings Clinic Provider Group, faxed upon completion to all other referring providers.
* Change in patient’s baseline status and/or initiation of reaction protocol will be immediately reported to the referring provider.
* If collecting lab series, **please provide preferred means for relaying results and/or desired parameters required to proceed and/or withhold treatment**. If not specified, treatment will be either held or given as directed based on current ***Wolters Kluwer/Up To Date*** administration guidelines.

***Thank you for allowing us to participate in your patient’s care-***

**Beartooth Billings Outpatient Services.**