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

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

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

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

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

**Diagnosis (select one/complete remaining ICD-10 Digits/Descriptors as needed):**

* M06.\_\_\_\_ -Rhematoid Arthritis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* M32.\_\_\_\_ -Systemic Lupus Erythematosus, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* L95.\_\_\_\_ -Vasculitis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* M33.\_\_\_\_ -Dermatomyositis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* G70.\_\_\_\_ -Myasthenia Gravis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* G35.\_\_\_\_ -Multiple Sclerosis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: Clinical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* 1,000 mg
* 500 mg
* 375 mg/m2
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_ Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Once Weekly x 4 Doses
* Once every two weeks x 2 Doses
* Q6 Months
* Q12 Months
* Other Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Order Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 all that have been completed and provide supporting documentation as indicated:**

* Hepatitis B Virus Screening Prior to first dose
* CMP, CBC, CRP and ESR required prior to every infusion during initiation and every 2-4 months every for ongoing treatment plan,
* For Lupus Patients, patient must be exhibiting refactory symptoms after 6 months of conventional therapy and failed CYC or MMF treatments or worsening after three months of treatment with glucocorticoids + CYC or MMF (provide supporting documentation)
* For MS patients, must have documented failure of first line therapy (typically ocrelizumab) or relapsing/remitting disease (provide supporting documentation)
* For Myasthenia Gravis patients, must have MuSK positive subtype.

**Standing Orders:**

* Reaction management protocol initiation for hypersensitivity/ anaphylaxis reaction.

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

* Hold and notify referring provider if: Creatinine less than 1.4mg/dL, TBIL less than 1.10 mg/dL, AST less than 150 u/L, and/or ALT less than 150 u/L
* For initial infusion, begin infusion rate at 50 mg/hr and increase rate by 50mg/hr every 30 minutes as tolerated for max rate of 400mg/hr. For subsequent doses, begin infusion rate at 100 mg/hr and increase rate by 100mg/hr as tolerated for max rate of 400 mg/hr.

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

* Complete Blood Count (CBC) with differential Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Comprehensive Metabolic Panel (CMP) Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* C-reactive Protein (CRP) Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ESR 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****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.**