Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Reclast (Zoledronic Acid) Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

Pre- Treatment Medications

Tylenol (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Benadryl (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

SOLU-Medrol (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Zoledronic Acid (Reclast)

☐ *4 mg, IV Piggyback, Soln-IV*
Comments: in 100ml NS infused IV over 15 minutes

☐ *5 mg, IV Piggyback, Soln-IV*
Comments: in 100ml NS infused IV over 15 minutes

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Reclast (Zoledronic Acid) Treatment Plan

Zoledronic Acid Infusion Frequency

☐ Administer as a onetime infusion

☐ Administer every _____ days for _____ doses

☐ Administer every _____ months for _____ doses

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Communication Order (Month 1 to 12)
Check BUN/CREAT within 1 week of each dose. If normal, Proceed with Infusion

☑ Communication Order (Month 1 to 12)
Ensure negative HCQ urine screening completed prior to each infusion for females 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy

☑ Notify Provider (Month 1 to 12)
Notify provider for temperature > 99.5 or HR < 55 or > 140, drop or rise in SBP more than 20 mm Hg from baseline

☑ Notify Provider (Month 1 to 12)
Notify provider if creatinine clearance less than 35mL/min. Do not infuse until provider approved.

☑ Notify Provider (Month 1 to 12)
for positive HCG urine screen prior to infusion initiation.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ HCG Pregnancy Screening- Urine (If Needed)
☑ BUN (If Needed)
☑ CMP (If Needed)
☑ CBC w/ Diff (If Needed)
☑ BMP (If Needed)

Patient Monitoring Acknowledgement:

***** CMC Outpatient Infusion Services (OIS) shall ensure negative HCG urine pregnancy screen is completed for females age 11-55 years of age with no history of hysterectomy or bilateral oophorectomy. Referring provider acknowledges that patients who fall into this category for screening have been educated about the reproductive risks associated with teprotumumab infusion, the need for screening prior to each infusion, and have received counseling related to the need for effective contraception during treatment and for a minimum of 6 months following therapy completion.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____