SOLEO HEALTH®
Simplifying Complex Care

Asthma & Allergy Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐ Allergies		
ICD-10 code (required)		ICD-10 description	
Patient Status: ☐New to Therapy ☐Previously Treated		Tried and failed meds ☐Yes ☐No If yes: _____	

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐ Insurance Cards	☐ History & Physical	☐ Most Recent Labs	☐ Medication List

ASTHMA & ALLERGY TREATMENT PLAN

☐ Fasenra®
- ☐ Adminsiter 30mg subcutaneous every 4 weeks for the first 3 doses, then 30mg every 8 weeks thereafter

☐ Tezspire®
- ☐ Administer 210mg subcutaneously every 4 weeks

☐ Dupixent®
- ☐ 400mg subcutaneously followed by 200mg every 2 weeks (patients < 60kg)
- ☐ 600mg subcutaneously followed by 300mg every 2 weeks (patients > 60kg)
- ☐ _____mg subcutaneously every _____ weeks

☐ Nucala®
- ☐ Administer _____mg subcutaneously every ____ weeks

☐ Xolair®
- ☐ Administer _____mg subcutaneously every ____ weeks

☐ Other	Include dosage, frequency and any other special instructions.

☐ Refill for 1 year

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Soleo's infusion protocol.

☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Soleo Health to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Soleo Health at phone 844.575.1515, fax 844.797.5050, or email specialtyreferrals@soleohealth.com.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____

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