

## Gastroenterology 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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
<input type="checkbox"/> NKDA		<input type="checkbox"/> Allergies	
ICD-10 code (required)		ICD-10 description	
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy		TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No

### PRESCRIBER INFORMATION

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

### REQUIRED DOCUMENTATION

<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List
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### GASTROENTEROLOGY TREATMENT PLAN

<input type="checkbox"/> Remicade <sup>®</sup> or Biosimilar _____ Loading dose: 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter	
<input type="checkbox"/> Entyvio <sup>®</sup> <input type="checkbox"/> 300 mg infused IV at 0, 2, and 6 weeks, then every _____ weeks thereafter.	
<input type="checkbox"/> Stelara <sup>®</sup> 130 mg (5mg/ml) single dose vials for intravenous use : <div style="float: right;"> <input type="checkbox"/> (≤55kg) 260 mg IV over 1 hour x 1 dose  <input type="checkbox"/> (55kg to 85 kg) 390 mg IV over 1 hour x 1 dose  <input type="checkbox"/> (&gt;85kg) 520 mg IV over 1 hour x 1 dose         </div> <input type="checkbox"/> Maintenance: Inject 90mg - (2x - 45mg ) SC 8 weeks after the initial IV infusion then every 8 weeks thereafter	
<input type="checkbox"/> Skyrizi <sup>®</sup> <input type="checkbox"/> Loading Doses - Infuse 600 mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Maintenance Dose - Inject 360 mg SC at week 12 and then every 8 weeks thereafter	
<input type="checkbox"/> Other	Include dosage, frequency and any other special instructions.
<input type="checkbox"/> 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

<input type="checkbox"/> Include premedication per Soleo's infusion protocol. <input type="checkbox"/> Other _____
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### LABORATORY ORDERS

<input type="checkbox"/> CBC every _____ <input type="checkbox"/> CMP every _____ <input type="checkbox"/> Other _____
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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