

Immunoglobulin 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		Last Treatment Date		

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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IMMUNOGLOBULIN TREATMENT PLAN

Soleo Health will select the product based on clinical indication, product availability and payor requirements.

Administration Route <input type="checkbox"/> IV <input type="checkbox"/> SCIG		<input type="checkbox"/> Allow rounding to the nearest 5 gram vial size.
<input type="checkbox"/> Primary Immunodeficiency (PI)	___gm/kg every ___ weeks	Dosing Range: 0.4-0.8 gm/kg every 3-4 weeks
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Loading ___ gm/kg; OR ___ grams divided equally over ___ days. Dosing Range: 2 gm/kg	
	Maintenance ___ gm/kg; OR ___ grams divided equally over ___ days, every ___ weeks Dosing Range: 1 gm/kg every 3-4 weeks	
<input type="checkbox"/> Other	Include dosage, brand preference, 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: _____

LABORATORY ORDERS

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