

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				

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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AMVUTTRA TREATMENT PLAN

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 ml
 25 mg via subcutaneous injection once every 3 months
 • Quantity: one (1) prefilled syringe
 Refills: Refill x3 Other:
 List or attach a list of concomitant medications and any special instructions:

ANCILLARY ORDERS

Anaphylaxis Kit
 Does this patient require an anaphylaxis kit? Yes, with 1st dose Yes, with all doses
 • Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
 • Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.

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