

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: specialityreferrals@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		Discharge Date	SOC 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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ASTHMA & ALLERGY TREATMENT PLAN

<input type="checkbox"/> Fasena® <input type="checkbox"/> Administer 30mg subcutaneous every 4 weeks for the first 3 doses, then 30mg every 8 weeks thereafter
<input type="checkbox"/> Tezspire® <input type="checkbox"/> Administer 210mg subcutaneously every 4 weeks
<input type="checkbox"/> Dupixent® <input type="checkbox"/> 400mg subcutaneously followed by 200mg every 2 weeks (patients < 60kg) <input type="checkbox"/> 600mg subcutaneously followed by 300mg every 2 weeks (patients > 60kg) <input type="checkbox"/> _____mg subcutaneously every _____ weeks
<input type="checkbox"/> Nucala® <input type="checkbox"/> Administer _____mg subcutaneously every _____ weeks
<input type="checkbox"/> Xolair® <input type="checkbox"/> Administer _____mg subcutaneously every _____ weeks
<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: _____

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 specialityreferrals@soleohealth.com.

Prescriber Name (Print)

Prescriber Signature

Date