SOLEO HEALTH®
Simplifying Complex Care

Bleeding Disorders 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: 844.747.4040 | f: 844.797.5050 | e: bleedingdisorders@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 ☐Continuing Therapy		TB Skin Test ☐Yes ☐No	Hepatitis B Screen ☐Yes ☐No

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

BLLEDING DISORDER TREATMENT PLAN

☐ Prime Therapeutics + Express Scripts may require separate rx for factor prophylaxis + bleed; others may allow combined, subject to plan
- ☐FACTOR: _____ IV _____ units, mg +/-10% (or___%) _____ _____doses refills____
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☐ HEMLIBRA® OK to dispense whole vials, 30, 60, 105, 150 mg or non-30mg combos to reach dose, waste the rest
- ☐HEMLIBRA® Load SQ: ☐Not applicable _____ mg once weekly x _____ weeks (usually 4 unless doses given) _____dose
- ☐HEMLIBRA® Maintenance SQ (start week 5)_____ mg _____ _____doses refills___

☐ Amicar 25% oral solution bottles = 237ml, Amicar and Lysteda tabs please prescribe per multiple of 30 tabs
- ☐Other Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____
- ☐Other Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____
- ☐Other Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____

☐ Sodium chloride 0.9% 10 ml prefilled syringe Flush IV with _____ ml _____ _____ syr refills____

☐ Heparin ☐10 unit/ml ☐100 unit/ml 5 ml prefilled syringe Flush IV with _____ ml _____ _____ syr refills____

☐ Emla 30 gram cream (topical) _____ _____tubes refills____

☐ Epi-pen 2-pack ☐Jr. 0.15mg ☐0.3 mg IM _____ _____2-pks refills____

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

Delivery needed by (special circumstances, bleed, procedure date, etc.):_____

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 _____