

Multiple Sclerosis 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: specialtyspecialtyreferrals@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				

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 Office Visit Notes	<input type="checkbox"/> Medication List
<input type="checkbox"/> CAS Score	<input type="checkbox"/> Thyroid Labs T3, T4 and TSH		

OPHTHALMOLOGY TREATMENT PLAN

Tepezza® 500 mg vial for intravenous use Prior to administration
Dilute doses <1800mg in 100 mLs 0.9% Sodium Chloride and doses ≥ 1800mg in 250 mLs 0.9% Sodium Chloride.
Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first two infusions over 90 minutes. If well tolerated, subsequent infusions may be reduced to 60 minutes.
Dose: Week 0: mg (10mg/kg) Week 3: mg (20mg/kg)
 21 day supply; 1 prescription; no refill 21 day supply; 1 prescription; 6 refills

Other _____
Include dosage, frequency and any other special instructions.

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

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 specialtyspecialtyreferrals@soleohealth.com.

Prescriber Name (Print)

Prescriber Signature

Date