



Infectious & Autoimmune Encephalitis (IAE) - Neuroinflammatory Disorders Referral Form

Please complete and fax the referral form to
IAEreferrals@soleohealth.com | p: 866.288.8250 | f: 866.288.8698

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.)	
PRESCRIBER INFORMATION					
Ordering Prescriber			Prescriber NPI		
Practice Name			Phone	Fax	
Practice Address		City	State	Zip	
ICD 10 DIAGNOSTIC CODES AND DESCRIPTIONS (include all that apply)					
ICD 10 Code	Description				
REQUIRED DOCUMENTATION					
<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> HPI and Clinical Encounter Notes (if applicable, the 3 most recent)	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List		
ADDITIONAL INFORMATION (if Available from the Patient's Medical History)					
Supportive Diagnostic Testing					
<input type="checkbox"/> CSF testing	<input type="checkbox"/> CT (chest, abdomen, pelvis, paranasal sinus)	<input type="checkbox"/> ECG	<input type="checkbox"/> EEG		
<input type="checkbox"/> MRI	<input type="checkbox"/> PET or SPECT		<input type="checkbox"/> PSG (Polysomnography)		
Blood Tests					
<input type="checkbox"/> Antinuclear Antibody Panel (ANA)			<input type="checkbox"/> Immunoglobulin Quantitative: IgG, IgA, IgM		
<input type="checkbox"/> Anti-Streptolysin O (ASO)			<input type="checkbox"/> Lymphocyte subset panel (both absolute and percentages) CD3, CD4, CD8, CD19 and CD56		
<input type="checkbox"/> Autoimmune Brain Panel (formally known as the Cunningham Panel)			<input type="checkbox"/> Serologic testing for infectious causes (Bacteria, Viruses, Parasites)		
<input type="checkbox"/> CBC, CMP			<input type="checkbox"/> Serum testing for antibodies associated with autoimmune encephalitis		
<input type="checkbox"/> Erythrocyte Sedimentation Rate (ESR), C-reactive protein, Ferritin			<input type="checkbox"/> Streptococcus Pneumonia Antibody		
<input type="checkbox"/> Immunoglobulin (IgG) subclass panel (1-4)			<input type="checkbox"/> Thyroid peroxidase (TPO) and Thyroglobulin (Tg) Antibody test		
<input type="checkbox"/> Neurocognitive Tests					
<input type="checkbox"/> Assessments, Scales, Questionnaires					
<input type="checkbox"/> Other					

TREATMENT PLAN

IMMUNOGLOBULIN

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

Administration Route IV SCIG Allow rounding to the nearest 5 gram vial size
 Loading gm/kg x days
 Maintenance gm/kg x days, every weeks

OTHER TREATMENTS Include dosage, brand preference, frequency, and any other special instructions

PREMEDICATION

- NaCl 0.9% (IV prior to IG)
- NaCl 0.9% (IV post IG)
- Dexamethasone IV
- Methylprednisolone IV

- Emla cream (or generic equivalent)
PRN for peripheral IV or port
- Ondansetron, orally disengaging tablet (ODT)
- OTHER:

Dispense as written Substitution Permitted

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.

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