SOLEO HEALTH®
Simplifying Complex Care

Immunoglobulin 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: specialtyreferrals@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

IMMUNOGLOBULIN TREATMENT PLAN

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.

☐ **Primary Immunodeficiency (PI)**	____gm/kg every ___ weeks	Dosing Range: 0.4-0.8 gm/kg every 3-4 weeks
☐ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**	**Loading** ___ gm/kg; OR ___ grams divided equally over __ days. Dosing Range: 2 gm/kg	
	Maintenance___ gm/kg; OR ___ grams divided equally over ___days, every ___weeks Dosing Range: 1 gm/kg every 3-4 weeks	
☐ **Other**	Include dosage, brand preference, 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 specialtyreferrals@soleohealth.com.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____