

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

This form is not a valid prescription

✂ Please detach before submitting to a pharmacy. Cut or tear here.

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		Date
ICD-10 code (required)		ICD-10 description	
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No	
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
BLEEDING DISORDER TREATMENT PLAN			
<input type="checkbox"/> Prime Therapeutics + Express Scripts may require separate rx for factor prophylaxis + bleed; others may allow combined, subject to plan <input type="checkbox"/> FACTOR: _____ IV _____ units, mg +/-10% (or ___%) _____ doses refills____ <input type="checkbox"/> FACTOR: _____ IV _____ units, mg +/-10% (or ___%) _____ doses refills____ <input type="checkbox"/> FACTOR: _____ IV _____ units, mg +/-10% (or ___%) _____ doses refills____			
<input type="checkbox"/> HEMLIBRA® OK to dispense whole vials, 30, 60, 105, 150 mg or non-30mg combos to reach dose, waste the rest <input type="checkbox"/> HEMLIBRA® Load SQ: <input type="checkbox"/> Not applicable _____ mg once weekly x _____ weeks (usually 4 unless doses given) _____ dose <input type="checkbox"/> HEMLIBRA® Maintenance SQ (start week 5) _____ mg _____ doses refills____			
<input type="checkbox"/> Amicar 25% oral solution bottles = 237ml, Amicar and Lysteda tabs please prescribe per multiple of 30 tabs <input type="checkbox"/> Other Med _____ (po,nas,SQ,IV) _____ (mg,ml,spr) _____ qty _____ refills____ <input type="checkbox"/> Other Med _____ (po,nas,SQ,IV) _____ (mg,ml,spr) _____ qty _____ refills____ Other <input type="checkbox"/> Med _____ (po,nas,SQ,IV) _____ (mg,ml,spr) _____ qty _____ refills____			
<input type="checkbox"/> Sodium chloride 0.9% 10 ml prefilled syringe Flush IV with _____ ml _____ syr refills____			
<input type="checkbox"/> Heparin <input type="checkbox"/> 10 unit/ml <input type="checkbox"/> 100 unit/ml 5 ml prefilled syringe Flush IV with _____ ml _____ syr refills____			
<input type="checkbox"/> Emla 30 gram cream (topical) _____ tubes refills____			
<input type="checkbox"/> Epi-pen 2-pack <input type="checkbox"/> Jr. 0.15mg <input type="checkbox"/> 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		LABORATORY ORDERS	
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol. <input type="checkbox"/> Other _____		<input type="checkbox"/> CBC every _____ <input type="checkbox"/> CMP every _____ <input type="checkbox"/> Other _____	

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

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.