

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

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		
IMMUNOGLOBULIN TREATMENT PLAN					
The Pharmacy will select the product based on clinical indication, product availability and payor requirements.					
Administration Route <input type="checkbox"/> IV <input type="checkbox"/> SCIG			<input type="checkbox"/> Allow rounding to the nearest 5 gram vial size.		
<input type="checkbox"/> Primary Immunodeficiency (PI)	___gm/kg every ___ weeks		Dosing Range: 0.4-0.8 gm/kg every 3-4 weeks		
<input type="checkbox"/> 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				
<input type="checkbox"/> Other	Include dosage, brand preference, frequency and any other special instructions.				
<input type="checkbox"/> 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			LABORATORY ORDERS		
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.			<input type="checkbox"/> CBC every _____		
<input type="checkbox"/> Other _____			<input type="checkbox"/> CMP every _____		
			<input type="checkbox"/> Other _____		

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.