

# Ophthalmology 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					
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"/> CAS Score		<input type="checkbox"/> Thyroid Labs T3, T4 and TSH		<input type="checkbox"/> Medication List	
OPHTHALMOLOGY TREATMENT PLAN					
<input type="checkbox"/> 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) <input type="checkbox"/> 21 day supply; 1 prescription; no refill <input type="checkbox"/> 21 day supply; 1 prescription; 6 refills					
<input type="checkbox"/> Other    Include dosage, 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"/> Other _____			<input type="checkbox"/> CBC every _____ <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.