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 ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐NKDA	☐Allergies		Date
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

BLLEDING DISORDER TREATMENT PLAN

☐ Prime Therapeutics + Express Scripts may require separate rx for factor prophylaxis + bleed; others may allow combined, subject to plan
- ☐FACTOR: _____ IV _____ units, mg +/-10% (or___%) _____ _____doses refills____
- ☐FACTOR: _____ IV _____ units, mg +/-10% (or___%) _____ _____doses refills____
- ☐FACTOR: _____ IV _____ units, mg +/-10% (or___%) _____ _____doses refills____

☐ HEMLIBRA® OK to dispense whole vials, 30, 60, 105, 150 mg or non-30mg combos to reach dose, waste the rest
- ☐HEMLIBRA® Load SQ: ☐Not applicable _____ mg once weekly x _____ weeks (usually 4 unless doses given) _____dose
- ☐HEMLIBRA® Maintenance SQ (start week 5)_____ mg _____ _____doses refills___

☐ Amicar 25% oral solution bottles = 237ml, Amicar and Lysteda tabs please prescribe per multiple of 30 tabs
- ☐Other Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____
- ☐Other Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____ Other
- ☐Med_____(po,nas,SQ,IV) _____(mg,ml,spr)_____ qty _____ refills____

☐ Sodium chloride 0.9% 10 ml prefilled syringe Flush IV with _____ ml _____ _____ syr refills____

☐ Heparin ☐10 unit/ml ☐100 unit/ml 5 ml prefilled syringe Flush IV with _____ ml _____ _____ syr refills____

☐ Emla 30 gram cream (topical) _____ _____tubes refills____

☐ Epi-pen 2-pack ☐ Jr. 0.15mg ☐ 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

☐ Include premedication per Pharmacy's infusion protocol.

☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ 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).