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 ☐ 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

IMMUNOGLOBULIN TREATMENT PLAN

The Pharmacy 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 Pharmacy's infusion protocol.

☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ 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.