

Amyotrophic Lateral Sclerosis 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		Discharge Date	SOC Date	

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
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ALS TREATMENT PLAN

<input type="checkbox"/> Radicava® <input type="checkbox"/> Initial treatment: Administer 60mg IV over 60 minutes daily for 14 days, followed by a 14 day drug-free period <input type="checkbox"/> Subsequent treatment cycles <input type="checkbox"/> Administer 60mg IV over 60 minutes daily for 10 days within a 14 day period, followed by a 14 day drug-free period Repeat every 28 days x _____ cycles
<input type="checkbox"/> Radicava ORS® Administer 105mg (5mL) orally or via feeding tube <input type="checkbox"/> Initial treatment: Daily dosing for 14 days, followed by a 14 day drug-free period <input type="checkbox"/> Subsequent treatment cycles: Daily dosing for 10 days out of a 14 day period, followed by a 14 day drug-free period
<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

<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.
<input type="checkbox"/> Other _____

LABORATORY ORDERS

<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.