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

BLLEEDING 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____
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☐ 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).

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.

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