SOLEO HEALTH
Innovators in Specialty Infusion

# Autoimmune Referral Form

Please complete the following and fax with clinical documentation to:
**844.797.5050 or email to CenterSource@soleohealth.com**

## REFERRAL PROCESS

| 1. PATIENT INFORMATION | 2. PHYSICIAN INFORMATION |
|---|---|
| Name: | Physician's name: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Home Phone: Other Phone: | Office Contact: |
| Email: DOB: | Phone: Fax: |
| Gender: ☐ M ☐ F Height: Weight: | NPI: |

Allergies: ______________________________________________________

### 3. DIAGNOSIS Year of diagnosis: _____

- ☐ CIDP (G61.81)
- ☐ Dermatopolymyositis (prev. known as Dermatomyositis) (M33.10)
- ☐ Guillain Barré Syndrome (G61.0)
- ☐ Multifocal Motor Neuropathy (G61.82)
- ☐ Multiple Sclerosis (MS Relapsing/Remitting) (G35)
- ☐ Myasthenia Gravis w/o acute exac. (G70.00)
- ☐ Myasthenia Gravis with acute exac. (G70.01)
- ☐ Polymyositis (M33.20)
- ☐ Pemphigus Vulgaris (L10.0)
- ☐ Stiff Person Syndrome (G25.82)
- ☐ Other: ______________________

### 4. INSURANCE INFORMATION - Please submit copies of the front and back of primary and secondary insurance cards with this referral.

### 5. ADDITIONAL INFORMATION REQUESTED

Previous IG received: ____________________ Last infusion date: _______________

Last BUN/SCR _____ ☐ H&P ☐ Nerve Conduction Study results/velocities ☐ Biopsy Results ☐ EMG Results ☐ CSF Results

☐ Other: _____

### 6. PRESCRIPTION INFORMATION Anticipated Start Date: _____

*Immune Globulin* Product: ____________________________________________ ☐ IV ☐ SQ

Administer _____ grams daily for _____ day(s) OR _____ grams/kilogram daily over _____ day(s)

Repeat course every _____ week(s) for a total of _____ courses/cycles

☐ Pre-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

☐ Pre medicate:

- ☐ Acetaminophen 325-650mg PO prior to IG and then Q4-6 hours as needed during infusion
- ☐ Diphenhydramine 25-50 mg PO prior to IG
- ☐ Other premedication: ____________________

☐ Post-hydrate with: ☐ NS ☐ D5W ☐ Other: _____ _____ ml IV over _____ hours

Provide supplies necessary to maintain IV Access: ☐ PIV ☐ Midline/PICC ☐ Port Administration method: ☐ Pump ☐ Dial-a-flow

### 7. FLUSH ORDERS

**PIV/midline/PICC:** Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

**Port:** Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml. (Use Heparin 10 unit/ml for patients <2 years old)

### 8. ANAPHYLAXIS ORDERS

**Adults:** For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

**Pediatrics:** administer by age: *For mild reaction (rash/hives) give diphenhydramine*
**Age 1-5:** 12.5ml IV/PO x1 **Age 6-11:** 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1
*For severe reaction (airway closure) administer epinephrine.* 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: ____________________

**9. NURSING ORDERS:** Skilled nursing to insert, maintain and remove/de-access vascular access daily, weekly and/or as needed, draw labs as ordered, conduct patient assessments, and educate patient/caregiver on home infusion, medication administration, self-monitoring, and patient safety.

10. ☐ Dispense as written ☐ Substitution Permitted

**PHYSICIAN'S SIGNATURE (required):** ______________________________ **Date:** _______________

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. www.soleohealth.com ©Soleo Health. All Rights Reserved. 06.20