



Saphnelo Order Form

Select patient referral location: **Akron** **Athens** **Blue Ash** **Cleveland** **Columbus** **Crestview Hills**
Dayton **Mansfield** **Perrysburg** **Springfield** **Toledo** **West Cincinnati**

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

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1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg
Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

☐ Systemic Lupus Erythematosus (_____) ☐ ICD 10 (_____) ☐ Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

SAPHNELO

- ☐ Administer 300mg IV Q4 weeks
- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other: _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
- ☐ Prednisone _____ mg PO
- ☐ Other: _____

6. LABS

- | | | |
|--|--|---|
| ☐ CBC w/Diff | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ CRP | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ CMP | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ ESR | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ Hepatic Panel | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ Renal Panel | ☐ each infusion | ☐ Other frequency (specify): _____ |
- ☐ Quantiferon TB Gold, annually, last completed (date): _____
- ☐ Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE