Saphnelo

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Demographics and insurance. Relevant, recent office notes. Current medication list.

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ M32 Systemic Lupus Erythematosus (SLE)

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PREMEDS

☐ Other:

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

SAPHNELO DOSAGE

Date of Last Treatment, If Continuation: _____

☐ **300 mg Every 4 Weeks**

☐ **Other:** _____ **Duration:** _____

Route: ☑ IV Start Date of Infusion: _____

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: ☐ List: _____

☐ Prior to first appointment ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.