

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



ORDER FORM SAPHNELO®

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION	
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

SAPHNELO*:

____ Dosing: 300 mg IV every 4 weeks

____ Other

Frequency:

☐ every 4 week

☐ other _____

Route:

☐ every 4 week

☐ other _____

Physician Signature _____

Date (Order is Valid for One Year) _____

Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

____ Systemic lupus erythematosus (SLE)

____ Other _____

REQUIRED DOCUMENTATION CHECKLIST:

____ Patient Demographics

____ Insurance Card/Information

____ Clinical/Progress Notes supporting DX

____ Current Medication List and H&P

____ Positive ANA lab results (if available)

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: ____ CMP ____ CBC ____ Labs to be drawn by Infusion Center *Frequency _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____