

Westerville  
575 Copeland Mill Road  
Suite# 2F  
Westerville, Ohio 43081



Lancaster  
2405 Columbus Street  
Suite# 210  
Lancaster, Ohio 43130

# 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

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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 \_\_\_\_\_