

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|---------------------------|---------------------------|-------------------------|--------------------|---------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Medication List | 5. Most Recent Labs |
| 6. Tried/Failed Therapies | 7. ANA or anti-dsDNA Labs | PGA Score_____ | SLEDAI score_____ | |

PRIMARY DIAGNOSIS

- M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
 M32.14 Glomerular disease in Systemic upus erythematosus M32.19 Other organ or system involvement in Systemic Lupus Erythematosus
 M32.8 Other forms of Systemic lupus erythematosus M32.9 Systemic lupus erythematosus, unspecified
 Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: There are no recommended standard pre-meds for Saphnelo
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Saphnelo 300mg IV every 4 weeks
 Other _____ FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

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PROVIDER SIGNATURE _____ DATE _____