175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _________ ok the switch to biosimilar if insurance formulary prefers

ORDER FORM SAPHNELO

Date: ________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
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

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________________________

Last Infusion/Injection Date: ________________________

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)

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

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ______________________________________ Date _______________

Provider ______________________________ Phone_____________ Fax _______________