



**Checklist for Saphnelo Referral**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Referring Office Contact/Title: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Best contact number for physician in case of reaction: \_\_\_\_\_

*Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.*

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). \*Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Saphnelo
  - Medication list and allergies
- Supporting lab reports/orders for Saphnelo treatment
  - *Recommended:* baseline CBC w diff and monitor periodically with treatment
- Saphnelo Prescribing Order (see attached)

**-- We will obtain prior authorization and schedule your patient as soon as possible --**

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**Fax all information to our Infusion Coordinator: 508-698-8671**

Call with any questions: 781-551-5812 ext. 112

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Visit our website: [www.InfusionCenterNE.com](http://www.InfusionCenterNE.com)

Email: [info@infusioncenterne.com](mailto:info@infusioncenterne.com)

**Infusion Center of New England**

9 Payson Road, Suite 100, Foxboro MA 02035

Ph: 781-551-5812

Fax: 508-698-8671



**Prescribing Order: Saphnelo**

Date of Order: \_\_\_\_\_

New Start     Maintenance

Date of last infusion: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F: \_\_\_\_\_

Diagnosis (include ICD-10 code/s): \_\_\_\_\_

NKDA    Allergies: \_\_\_\_\_

Patient Weight: \_\_\_\_\_

**Premedication:**

- |  |  |
|--|--|
| <input type="checkbox"/> Acetaminophen 1000mg PO               | <input type="checkbox"/> Diphenhydramine 25mg IV |
| <input type="checkbox"/> Loratadine 10mg or Cetirizine 10mg PO | <input type="checkbox"/> Solu-medrol 125mg IV    |
| <input type="checkbox"/> Diphenhydramine 25mg PO               | <input type="checkbox"/> Other: _____            |

**Lab Orders:**

- CBC w/diff every \_\_\_\_\_ weeks
- Other: \_\_\_\_\_

**Saphnelo Medication Order**

Saphnelo 300mg IV in 100ml Normal Saline infused over 30 minutes

Frequency:     Every 4 weeks                       Other: \_\_\_\_\_

**Administration:**

- ✓ Infuse Saphnelo over at least 30 minutes with in-line 0.2 micron filter.
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

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**Ordering Provider Name** \_\_\_\_\_ **NPI** \_\_\_\_\_

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**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_