INFUSION CENTER OF NEW ENGLAND

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 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
18 Washington Street, 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:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV
❑ 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.

Ordering Provider Name **NPI**

Signature **Date**

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