BioTek reMEDys®

SAPHNELO®

Please Fax Completed Form To: **800-783-9146**

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ DEA: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

City, State, Zip: _____

Plan #: _____

Group #: _____

Phone: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

City, State, Zip: _____

Group #: _____

Phone: _____

CLINICAL INFORMATION

☐ M32.10- SLE, organ or system involvement, unspecified

☐ M32.11- Endocarditis in systemic lupus erythematosus

☐ M32.12- Pericarditis in systemic lupus erythematosus

☐ M32.13- Lung involvement in systemic lupus erythematosus

☐ M32.14- Other specified rheumatoid arthritis, multiple sites

☐ M32.15- Tubulo-interstitial nephropathy in systemic lupus erythematosus

☐ M32.19- Other organ or system involvement in systemic lupus erythematosus

☐ Other diagnosis: _____ ICD-10 Code (Required): _____

DRUG ORDERS – may not be needed

Medication	Directions	Quantity/Refills
☐ Saphnelo IV Order	300 mg/2 mL every 4 weeks	Quantity: _____ Refills: _____

Pre-medication: _____

ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) - Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) - Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

☐ Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

☐ Other Orders: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature