

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
--	------------------------

Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	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
<input type="checkbox"/> 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

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.