# *Intravene* – Saphnelo Infusion Orders (rev 4/2022)

**Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 3001**

**PATIENT INFORMATION**

Name ______________________________
Address ______________________________
City ______________________________
State _____________ Zip Code ________
Home Phone # ________________________
Work Phone # ________________________
DOB _________SSN _________________
Height ___________ Weight ________lbs
Drug Allergies________________________
□ NKDA Sex: □ Male or □ Female

**REFERRING PHYSICIAN INFORMATION**

Physician Name ___________________________
Physician Address_________________________
__________________________________________
Physician Phone(_____)_____________________
Physician Fax(____)________________________
NPI#__________________DEA#_____________
State License#_____________________________

****Please fax copies of insurance cards, clinical documents and this form to 434-455-5531****

**DIAGNOSIS (ICD-10 required)**

- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

**PRESCRIPTION:**

**Dispense: Saphnelo 300mg in Normal Saline 100ml IV over 30 minutes every 4 weeks. Flush with 20ml Normal Saline after infusion.**

**Duration: □ 1 year □ other____________**

**PREMEDICATIONS:**

- ☐ Premed: ___________________________ Dose: ________mg _______min prior to infusion
- ☐ Premed: ___________________________ Dose: ________mg _______min prior to infusion
- ☐ Premed: ___________________________ Dose: ________mg _______min prior to infusion

**ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL**

**Signature, prescribing MD ________________________ Date: _______________**