

# LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

Please fax completed form, insurance card, and clinical documentation to:  
**FAX: (843) 793-6181**

## SAPHNELO ORDER

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

### Indication:

- M32.1\_\_ Systemic lupus erythematosus
- M32.8 Other forms of systemic lupus erythematosus
- M32.9 Systemic lupus erythematosus, unspecified
- Other \_\_\_\_\_

### DRUG:

- 300mg IV every 4 weeks
- Other \_\_\_\_\_

### PREMEDICATION ORDERS: *not required by PI*

- Acetaminophen po:  1000mg  500mg 30 min prior to infusion.
- Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion.
- Solu-Medrol:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.
- Other \_\_\_\_\_

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

### Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)

Most Recent Labs (within last 4-8 weeks) – Required:

- CBC  CMP  Lipids  TB  Hep B Other: \_\_\_\_\_