AYSA
THERAPEUTICS INFUSION

SAPHNELO ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/ Progress note, labs, and test supporting primary diagnosis attached

☐ SLE Disease Activity Index 2000 score _____

☐ Physician's Global Assessment score _____

Tried and failed medications: _____

Lab Orders: _____

SAPHNELO ORDERS

☐ 300mg IV every 4 weeks

**** Once we receive all necessary documentation, we will schedule the patient's treatment.**

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*., and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____

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