BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

SAPHNELO
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Systemic lupus erythematosus, unspecified (ICD-10 Code: M32.9)

☐ Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Saphnelo : ☐ 300mg IV every 4 weeks x 1 year

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR SAPHNELO THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance benefits, or contraindications to conventional therapy
- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)? ☐ Yes ☐ No If yes, which drug(s)? _____
- ☐ Has the patient tried and failed Benlysta therapy? ☐ Yes ☐ No
- ☐ Include labs and/or test results to support diag
- ☐ ANA, Anti-dsDNA, Anti-Ro/SSA, and/or anti-Smith antibodies
- ☐ Other medical necessity: _____

REQUIRED INFORMATION

- ☐ **ANA, Anti-dsDNA, Anti-Ro/SSA, and/or anti-Smith antibodies (attach)**
- ☐ **Tried and failed medications (attach)**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance