

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

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## SAPHNELO ORDER FORM

Patient Name: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

### Therapy Status

- New Start  
 Continuing Therapy: Last Dose: \_\_\_\_\_

## PROVIDER INFORMATION

Ordering Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_ Provider Address: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_

## MEDICATION ORDER

**Saphnelo**

✓ Administer Saphnelo 300mg IV over 30 minutes every four weeks.

Refills for one year from date of signature unless indicated below.

\_\_\_\_\_ Refills

## PRE-MEDICATIONS

### Oral

- Acetaminophen: \_\_\_\_\_ 325mg \_\_\_\_\_ 500mg \_\_\_\_\_ 650mg  
 Loratadine: 10mg  
 Cetirizine: 10mg  
 Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg  
 Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg  
 Ibuprofen: \_\_\_\_\_ 200mg \_\_\_\_\_ 400mg \_\_\_\_\_ 600mg  
 Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg  
 Other: \_\_\_\_\_

### IV

- Dexamethasone: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg  
 Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg  
 Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg  
 Methylprednisolone: 125mg  
 Hydrocortisone: 100mg  
 Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg  
 Other: \_\_\_\_\_

## LAB ORDERS (please indicate any labs to be drawn and frequency)

## OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date