

# SAPHNELO (IV) PRESCRIPTION AND REFERRAL FORM



## Patient Information

Please submit front and back copies of all medical & prescription insurance cards.

Patient Name: \_\_\_\_\_  Male  Female Primary Language: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_  
Alt Phone: \_\_\_\_\_ \*\*May we leave a message on either line?  YES  NO May we text you?  YES  NO  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_ Cardholder: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_ Cardholder: \_\_\_\_\_

## Clinical Information

Please submit clinic notes, medical history, labs, test results, and medication list.

Allergies:  NKDA  Other: \_\_\_\_\_ Access Type:  Peripheral  Implanted Port  Other: \_\_\_\_\_  
ICD-10: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Previous Therapy?  No  Yes, and Product Name: \_\_\_\_\_ Date of last treat: \_\_\_\_\_  
Ht: \_\_\_\_\_  IN  CM Wt: \_\_\_\_\_  LB  KG

## Prescription Order

Administered per manufacturer guidelines. Per state law, prescriptions will be dispensed as generic unless otherwise noted.

- Saphnelo®  Fixed dose: 300 mg diluted in 50-100 mL of Sodium chloride 0.9%.  
 Frequency: Administer over at least 30 minutes IV every 4 weeks. \*\* May adjust infusion schedule +/- 3 days if nursing need arises \*\*

ANCILLARY MEDICATIONS:  With every infusion  PRN upon patient request.  
 Acetaminophen \_\_\_\_\_ mg PO.  Give 30 to 60 minutes before infusion.  May repeat every \_\_\_\_\_ hours PRN.  
 Diphenhydramine \_\_\_\_\_ mg  PO  IV.  Give 30 to 60 minutes before infusion.  May repeat every \_\_\_\_\_ hours PRN.  
 SoluMedrol®  SoluCortef® Give \_\_\_\_\_ mg prior to infusion via  IV push, or  diluted in \_\_\_\_\_ mL of NS over 30 minutes.  
 Emla® cream (30 grams). Apply topically 30 to 60 minutes prior to access.  
 Other: \_\_\_\_\_

FLUSHING PROTOCOL:  Sodium chloride 0.9%, 5-10 mL before/after medication, and/or PRN to maintain patency.  
 Upon completion of infusion, flush IV line with 25-50 mL of Sodium chloride 0.9%.  
 Heparin \_\_\_\_\_ units/mL, \_\_\_\_\_ mL as final flush and/or PRN to maintain patency

ANAPHYLAXIS PROTOCOL: 1) Stop infusion. Call 911. 2) Administer medications below per protocol.  
Epinephrine (vial or autoinjector): Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes x 1.  
 0.3 mg (Wt > 30 kg)  0.15 mg (Wt 15-30 kg)  0.1 mg (Wt 7.5-15 kg)  
Diphenhydramine (50mg/mL vial) via IM or slow IV push  
 50 mg (Wt > 30 kg)  25 mg (Wt 15-30 kg)  12.5mg (Wt 7.5-15kg)  
 Sodium Chloride 0.9%, 500 mL IV as directed

NURSING / LABS / SUPPLIES:  
 Nursing visits with each infusion to establish venous access, administer medication, assess, and monitor patient, provide education, and complete lab draws.  
 Diluent, infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.  
 [Dx code: Z79.899] Labs as follows, to be drawn annually by RN prior to infusion unless frequency is specified: every \_\_\_\_\_ month(s)  
 CMP  CBC w/ diff  Other: \_\_\_\_\_  
 TB test shall be ordered at a frequency deemed appropriate and performed by an outside lab facility.

Dispense (all above):  up to 1-month supply + refills x 1 year  up to 3-month supply + refills x 1 year  Other: \_\_\_\_\_

## Prescriber Information

Prescriber: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date \_\_\_\_\_

I authorize IV Solutions Rx and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions Rx. CONFIDENTIALITY NOTICE: The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by replying by email at [info@ivsolutionsrx.com](mailto:info@ivsolutionsrx.com) and then destroying all copies of the original message.