Hy-Vee health

SAPHNELO
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

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:

☐ 300 mg IV every 4 weeks x1 year

Lab Orders: _____

Frequency: ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Other orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* 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 Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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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 diagnosis
☐ 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)**

Hy-Vee Health 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.

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