SAPHNELO

(anifrolumab-fnia)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- ANA or anti-dsDNA Labs

PRIMARY DIAGNOSIS

☐ M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
☐ M32.14 Glomerular disease in systemic lupus erythematosus
☐ M32.19 Other organ or system involvement in systemic lupus erythematosus
☐ M32.8 Other forms of systemic lupus erythematosus
☐ M32.9 Systemic lupus erythematosus, unspecified
☐ Other: ______________________________

PRE-MEDICATIONS

*Per infusion clinic protocol: No recommended standard pre-meds for Saphnelo
☐ Provider Prescribed: ______________________________

PRIMARY MEDICATION ORDER

☐ Saphnelo 300mg IV every 4 weeks
☐ Other: ______________________________

First Dose: Y ☐ N ☐ ☑ Refill x12 months unless otherwise noted: ______________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol
(See infusionspecialists.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________ Provider Signature

______________________________ Date