

# Saphnelo (anifrolumab-fnia)

## PATIENT INFORMATION

Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_

Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### PRE-MEDICATION ORDERS (OPTIONAL)

- acetaminophen (Tylenol)  500mg |  650mg |  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg |  50mg |  PO |  IV
- methylprednisolone (Solu-Medrol)  40mg |  125mg IV
- hydrocortisone (Solu-Cortef)  100mg IV
- Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency: \_\_\_\_\_

### THERAPY ADMINISTRATION

- Anifrolumab-fnia** (Saphnelo) 300mg in 100ml 0.9% sodium chloride
  - Dose: 300mg in 100ml NS
  - Route: intravenous
  - Frequency: once every 4 weeks
  - Infuse over 30 minutes
  - Flush with 0.9% sodium chloride at infusion completion
- Patient required to stay for 30-min observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
 (if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
 Provider Name (Print)

\_\_\_\_\_  
 Provider Signature

\_\_\_\_\_  
 Date