Patient Name:_______________________________________

DOB:______________________ Wt(kg):_________________

Allergies:___________________ Phone:_________________

SAPHNELO (anifrolumab-fnia) Infusion Orders

Required Information:

Signed order from prescribing provider

Patient demographics including insurance information

Supporting clinical documentation: Visit notes, diagnostic results

Primary Diagnosis:

Systemic Lupus Erythematosus (ICD-10 :____________)

Other:________________(ICD-10:_____________)

SAPHNELO ORDERS

Saphnelo 300mg IV every 4 weeks

Saphnelo _________mg IV every ___ weeks

Date of Last Saphnelo:_________

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

PO Loratadine _____mg

PO IV Diphenhydramine _____mg

PO IV Other:______________ _____mg

LABS

CBC

CMP

CRP

ESR

TB Quantiferon Gold

Hep B Core/Surface AG

Uric Acid

Other:______

Other:______

Frequency: Every Visit

Every Other Visit

One time only

Other:_____________

CPL Acct #:__________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

____

____

____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**