

Saphnelo (anifrolumab-fnia)

Provider Order Form rev. 4/10/2022

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

NURSING

Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

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