Saphnelo

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ M32.9 Systemic lupus erythematosus

◯ Other: ____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

Diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Cetirizine (Zyrtec) ◯ 10mg PO

Methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

Loratadine (Claritin) ◯ 10mg PO

Hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: ______________________________ Dose:_______________ Route:_______________ Frequency: _______________

MEDICATION ORDER

Saphnelo (anifrolumab-fnia) **Dose:** ◯ 300mg IV **Frequency:** ◯ every 4 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ◯ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.