

SAPHNELO (anifrolumab-fnia) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____ Systemic Lupus Erythematosus (SLE) ☐ _____ *other*

Pre-Medication:

☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☒ Patient Demographic Sheet
☒ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☒ ANA lab result & date *(please attach)*

SAPHNELO ORDERS:

Dosing: ☒ 300 mg diluted in 100 ml 0.9% sodium chloride, administer IV over 30 minutes

Frequency: ☐ Every 4 weeks ☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____