CURBSIDE INFUSION SERVICES

Saphnelo Order Form
(anifrolumab-fnia)

FAX TO: (713) 489-9955

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ M32.1 _____ Systemic lupus erythematosus with organ or system involvement

☐ Other _____

Prescribing information

Limitations of Use: The efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Saphnelo has not been studied in combination with other biologics therapies. Therefore, the use of Saphnelo is not recommended for use in combination with biologic therapies.

Evaluation of Immunizations: should be completed prior to, and live vaccines should not be given for 30 days before or concurrently with Saphnelo.

Missed Dose: Administer as soon as possible but maintain at least 14 days between infusions.

***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.**
***LAB RESULTS*: Lab testing documenting the presence of autoantibodies (i.e. ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)**

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25mg PO
☐ Diphenhydramine: 25mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
Other: _____

Saphnelo (anifrolumab-fnia)

Dose:

IV: infuse 300 mg in 100 mL of 0.9% Sodium Chloride over 30 minutes using a 0.2-micron filter every 4 weeks for one year.
After the infusion, flush with 25 mL of 0.9% Sodium Chloride.
In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments:

_____

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PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____