Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Saphnelo® (anifrolumab-fnia) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ M32.9 - Systemic Lupus erythematosus, unspecified

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Lab results and/or tests to support diagnosis		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE:Patient ***may be ineligible*** to receive anifrolumab-fnia if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	◯ 25mg	◯ 50mg		**PO**	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg ◯ 1000mg
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:		Famotidine	◯ 20mg	◯ 40mg	
	Famotidine	◯ 20mg	◯ 40 mg			Diphenhydramine	◯ 25mg	◯ 50mg	
	Other:	◯				Fexofenadine	◯ 60mg	◯ 180mg	
						Cetirizine	◯ 10mg		
						Loratadine	◯ 10mg		
						Other:	◯		

MEDICATION:

☑ Saphnelo® (anifrolumab-fnia) in NS given IV via pump over 30 minutes

DOSE:

◯ 300mg

◯ Other:_____

FREQUENCY:

◯ Every 4 weeks

◯ Other:_____

SPECIAL/LAB ORDERS:

◯ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023