

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> 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: <input type="checkbox"/> See list <input type="checkbox"/> 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	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg	PO	Acetaminophen	<input type="checkbox"/> 325mg	<input type="checkbox"/> 500mg	<input type="checkbox"/> 650mg	<input type="checkbox"/> 1000mg	
	Methylprednisolone	<input type="checkbox"/> 40mg	<input type="checkbox"/> 125mg		Other:	Famotidine	<input type="checkbox"/> 20mg	<input type="checkbox"/> 40mg		
	Famotidine	<input type="checkbox"/> 20mg	<input type="checkbox"/> 40 mg			Diphenhydramine	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg		
	Other:					Fexofenadine	<input type="checkbox"/> 60mg	<input type="checkbox"/> 180mg		
						Cetirizine	<input type="checkbox"/> 10mg			
				Loratadine	<input type="checkbox"/> 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 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



Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com