

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:

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 100ml 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:

NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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