

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

Rev 4.29.25

### PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		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 2<sup>ND</sup> AND 3<sup>RD</sup> 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	Lab results and/or tests to support diagnosis	THERAPY:	
			<b>Continue current order until insurance approved</b>

### 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

<b>IV</b>	Diphenhydramine	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg	<b>PO</b>	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) diluted in 100ml NS given IV via pump over 30 minutes.

Flush entire line with 25ml NS at the end of infusion.

### DOSE:

300mg  
 Other: \_\_\_\_\_

### SPECIAL/LAB ORDERS:

\_\_\_\_\_  
 \_\_\_\_\_

### FREQUENCY:

Every 4 weeks  
 Other: \_\_\_\_\_



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.

### 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