


SAPHNELO® (ANIFROLUMAB) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Saphnelo® (anifrolumab) Prescription

Saphnelo® (Anifrolumab) 300mg administered in a 50 mL 0.9% Sodium Chloride Injection, USP infusion bag as an intravenous infusion over a 30-minute interval using a 0.2-micron filter by a healthcare professional once every 4 weeks.

- Flush with 25ml of 0.9% Sodium Chloride Injection, USP at the end of infusion.

Ancillary Orders

Anaphylaxis Kit

- Epinephrine 0.3 mg SQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- Normal Saline 500ml IV at KVO rate PRN anaphylaxis or over 2 to 4 hours PRN headache rated >5 on pain scale.

Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If infusing via Peripheral IV, skilled nurse to insert.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

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