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Saphnelo (Anifrolumab-fnia) Infusion Order

Patient Name: DOB: □Male □Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen ______mg by □ PO
□ Cetirizine ______mg by □ PO
□ Diphenhydramine ______mg by □ PO/ □ IVP
□ Solu-Medrol ______mg by □ PO/ □ IVP
□ Solu-Cortef ______mg by □ PO/ □ IVP
□ Other:

RequiredDocumentation:

□ PatientDemographics
□ PatientInsurance (med and pharm card copies, front and back)
□ ProgressNotes/Labs supporting diagnosis
□ HepatitisBstatus and date
□ CBC, CMP,Quantiferon, ESR, CRP lab results
□ PositiveANA results
□ Other:

Patient height and weight:

Patient Height (cm): Patient Weight (kg):

Saphnelo Medication Order:

- Dosage (choose one):
  - □ 300 mg
  - □ Other: ___________________________
- Frequency(choose one):
  - □ Every 4 weeks
  - □ Other: ___________________________

Additional Instructions/Notes:

Ordering Provider:

Signature: ____ Date: _________________

Provider: ____ Phone: ________________ Fax: __________________

Best Contact Person in Office: ________________________________ Phone: ________________

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400