

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

**ICD 10 Code (PROVIDE COMPLETE CODE)**

M32.1 \_\_\_\_\_ Systemic lupus erythematosus with organ or system involvement

Other \_\_\_\_\_

**Prescribing information**

**Limitations of Use:** The efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Saphnelo has not been studied in combination with other biologics therapies. Therefore, the use of Saphnelo is not recommended for use in combination with biologic therapies.

**Evaluation of Immunizations:** should be completed prior to, and live vaccines should not be given for 30 days before or concurrently with Saphnelo.

**Missed Dose:** Administer as soon as possible but maintain at least 14 days between infusions.

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**  
**LAB RESULTS:** Lab testing documenting the presence of autoantibodies (i.e. ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)

## PRESCRIPTION

**Pre-Medications**

Acetaminophen: 650 mg PO                      Famotidine: 20 mg PO  
 Cetirizine: 10 mg PO                              Methylprednisolone: 125 mg SIVP  
 Diphenhydramine: 25mg PO                      Other: \_\_\_\_\_  
 Diphenhydramine: 25mg IVP

**Saphnelo (anifrolumab-fnia)**

**Dose:**

IV: infuse 300 mg in 100 mL of 0.9% Sodium Chloride over 30 minutes using a 0.2-micron filter every 4 weeks for one year. After the infusion, flush with 25 mL of 0.9% Sodium Chloride.  
 In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 30 minutes following the first infusion.

**Comments:**

\_\_\_\_\_  
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 \_\_\_\_\_  
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## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Supervising Physician: \_\_\_\_\_ (If Applicable)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_