medix infusion

Saphnelo Order Form
(antifrolumab-fnia)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ____________________

DOB: ____________ Phone: ____________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

DM32.9 Systemic Lupus Erythematosus, Unspecified

Other: ____________________

Weight: ________ lb kg Height: ________

Patient Status:

New to therapy

Continuing therapy (date of last dose ________)

Allergies: ____________________

PRESCRIPTION

Pre-Medications

Acetaminophen: 650 mg PO

Cetirizine: 10 mg PO

Diphenydramine: 25 mg PO

Diphenhydramine: 25 mg IVP

Famotidine: 20 mg PO

Methylprednisolone: 125 mg SIVP

Other: ____________________

SAPHNELO (anifrolumab-fnia)

- 300 mg IV every 4 weeks for one year

Is the patient on any other disease modifying therapy? **Yes** **No**

Is yes, please note therapy and last dose: ____________________

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol

Other Orders: ____________________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:

Lab testing documenting the presence of autoantibodies (i.e., ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ____________________

Signature: ____________________

NPI #: ____________________ Date: ____________

Supervising Physician (if applicable): ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Contact Name: ____________ Phone: ________ Fax: ________