Saphnelo® Order Form
(antifrolumab-fnia)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

Primary ICD 10 Code (Required)

☐ M32.9 Systemic Lupus Erythematosus, Unspecified

☐ Other: _____

Patient Status

☐ New to therapy

☐ Continuing therapy (date of last dose _____)

Medication Order

Pre-Medications

☐ Acetaminophen: 650 mg PO

☐ Cetirizine: 10 mg PO

☐ Diphenydramine: 25 mg PO

☐ Diphenhydramine: 25 mg IVP

☐ Famotidine: 20 mg PO

☐ Methylprednisolone: _____ mg SIVP

☐ Other: _____

SAPHNELO (anifrolumab-fnia)

300 mg IV every 4 weeks for one year

Adverse Events: In the event of an adverse reaction occurring at a MedixInfusion suite, utilize the Medix Infusion Adverse Reactions Protocol

Lab Orders

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Comments: _____

Required Clinical Documentation

- **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**

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

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

If yes, please note therapy and last dose:

_____

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____