SAPHNELO® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Systemic lupus erythematosus (SLE)

_____ Other: _____

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Recent Lab Results including any recent antibody testing results (i.e. ANA)

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **SAPHNELO® (anifrolumab-fnia)**

☐ ***New Start:***

300 mg per 100 ml Sodium Chloride 0.9% IV to infuse over 30 minutes every 4 weeks via pump with 0.2 or 0.22-micron filter. _____# Refills

Pre-Medication Orders: Acetaminophen: ☐ 650 mg PO ☐ 500 mg PO ☐ 325 mg PO
Diphenhydramine: ☐ 25 mg PO, ☐ 50 mg PO, ☐ 25 mg IVP, ☐ 50 mg IVP or
Fexofenadine ☐ 60mg or ☐ 180 mg, ☐ Cetirizine 10 mg, ☐ Loratadine 10 mg
Methylprednisolone ☐ 40 mg IVP ☐ 125 mg IVP or other mg IVP _____
Famotidine: ☐ 20 mg PO, ☐ 40 mg PO, ☐ 20 mg IVP, ☐ 40 mg IVP

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date