SAPHNELO® (ANIFROLUMAB) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**			
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Saphnelo® (anifrolumab) Prescription

Saphnelo® (Anifrolumab) 300mg administered in a 100 mL 0.9% Sodium Chloride Injection, USP infusion bag as an intravenous infusion over a 30-minute interval using a 0.2-micron filter by a healthcare professional once every 4 weeks x 1 year.

- Flush with 25ml of 0.9% Sodium Chloride Injection, USP at the end of infusion.

Ancillary Orders

Anaphylaxis Kit

- Epinephrine 0.3 mg SubQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If infusing via Peripheral IV, skilled nurse to insert.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

