SAPHNELO® (ANIFROLUMAB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:

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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

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