ID Infusion Center
CONSULTANTS INC

SAPHNELO (ANIFROLUMAB-FNIA)

FAX TO (216) 378-9824

FOR QUESTIONS, CALL (216) 360-0456

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Allergies: _____ Ht (in): _____ Wt (kg): _____ Gender: M | F

Demographic Information Attached: ◯ Yes

Insurance Information Attached (front and back of card): ◯ Yes

Infusion location: ◯ Beachwood ◯ Painesville ◯ Fairlawn ◯ Westlake ◯ Middleburg Heights ◯ Youngstown

Patient Status:
- ◯ New to Therapy
- ◯ Order Renewal
- ◯ Change of Dose | Frequency
- ◯ Continuing Treatment | Transfer from a Prior Site of Care. Next Treatment Due Date: _____

(Efforts will be taken to maintain treatment schedule, but next due date cannot be guaranteed)

2 CLINICAL INFORMATION

ICD-10 Code (required & as specific as possible): _____ ICD-10 Description: _____

Clinical/Progress Notes, Labs, Tests Supporting Primary Diagnosis Attached: ◯ Yes

Current SLE treatment(s): _____

Previous systemic lupus erythematosus (SLE) treatment(s): _____

Date of ANA /anti-dsDNA test: _____ Results: _____

3 INFUSION ORDER

Saphnelo: ◯ 300 mg administered as IV infusion over 30 mins, every 4 weeks.

Pre-Medication Order:

- ◯ Acetaminophen 650 mg PO
- ◯ Benadryl 25 mg IVP or PO (circle preference)
- ◯ Solu Cortef 200 mg IVP
- ◯ Solu Medrol 125 mg IVP

Comments/Special Considerations: _____

LAB REQUIREMENTS & LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBER. INFUSION ORDERS ARE VALID FOR ONE YEAR (UNLESS OTHERWISE SPECIFIED). INFUSIONS WILL BE ADMINISTERED PER ID CONSULTANTS INFUSION CENTER POLICY AND PROTOCOLS.

4 PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____