Fax your completed order to 877-734-1157

Patient Name: ____________DOB: ________/_________/___ Date of Last Infusion: _____________/___/_______
Height_______Weight_______
Infusion Location: (state and site) ________________________________

Saphnelo® (anifrolumab-fnia) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):	
_________Systemic lupus erythematosus (ICD-10)	_________Other: ____________________________ (ICD-10)

- Hold infusion and notify provider for
  - Abnormal vital signs or signs or symptoms of illness/active infection
  - Planned/recent surgical procedures or recent live vaccinations
  - New/worsening neurological symptoms or mood change
- Record vital signs before and after infusion and prior to discharge
- If an infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Protocol as clinically indicated

Premedications:____
____

- ❑ Administer Saphnelo 300mg IV every 4 weeks over 30mins in 100ml NS
- Infuse using 0.2 or 0.22micron low protein binding in line filter
- Flush IV line with 25ml NS after infusion has completed

Additional Orders:

Provider Name (print):____Date:____________________

Provider Signature: ____Time: ___________________

Reviewed 6/29/2022. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.