EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Saphnelo® Order Form
(antifrolumab-fnia)

FAX TO: 817-472-7213

Patient Information

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Diagnosis & Clinical Information

Primary ICD 10 Code (Required)

☐ DM32.9 Systemic Lupus Erythematosus, Unspecified
☐ Other:

_____

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:
☐ New to therapy
☐ Continuing therapy (date of last dose _____)

Allergies:
_____

Prescription

Pre-Medications
☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenydramine: 25 mg PO

☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
☐ Other: _____

SAPHNELO (anifrolumab-fnia)
- 300 mg IV every 4 weeks for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol

Other Orders:
_____

Required Medical Documentation

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
Lab testing documenting the presence of autoantibodies (i.e., ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)

Medix Infusion will collect all necessary labs if not included in referral documents

Prescriber Information

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____