

Saphnelo (anifrolumab-fnia)

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal
Infusion Office Preference: _____

PATIENT INFORMATION

Date:	Patient Name:	DOB:
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:	Next Due Date:	

PROVIDER INFORMATION

Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Systemic Lupus Erythematosus (SLE)	ICD 10 Code: M32.9
<input type="checkbox"/> Other:	ICD 10 Code:

REQUIRED DOCUMENTATION/Testing

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary dx
<input type="checkbox"/> Patient demographics AND insurance info	<input type="checkbox"/> Labs and Tests supporting primary diagnosis

List Tried & Failed Therapies 1) _____ 2) _____

PREMEDICATION ORDERS

acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 diphenhydramine (Benadryl) **PO / IV** 25mg 50mg (if route is not circled PO will be administered)
 methylprednisolone (Solu-Medrol) IV 60mg 100mg 125mg _____ mg
 Other:

MEDICATION ORDERS

Saphnelo 300 mg IV every 4 weeks

Refills*: None X6 months X1 year Other: _____
**(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Physician Signature: _____ Date: _____

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.