SAPHNELO
(anifrolumab-fnia)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies
• ANA or anti-dsDNA Labs

PRIMARY DIAGNOSIS

☐ M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
☐ M32.14 Glomerular disease in systemic lupus erythematosus
☐ M32.19 Other organ or system involvement in systemic lupus erythematosus
☐ M32.8 Other forms of systemic lupus erythematosus
☐ M32.9 Systemic lupus erythematosus, unspecified
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol: No recommended standard pre-meds for Saphnelo
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Saphnelo 300mg IV every 4 weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date