

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025B Waterside Rd  
Prince George, VA 23875

**Physician Order - Saphnelo (anifrolumab)**

| PATIENT INFORMATION |               |
|---------------------|---------------|
| Name:               | DOB:          |
| Allergies:          | Phone Number: |

| REFERRAL STATUS                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal |

| Location Preference (optional)                                           |
|--------------------------------------------------------------------------|
| <input type="checkbox"/> Richmond <input type="checkbox"/> Prince George |

\*\* If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access \*\*

| DIAGNOSIS AND ICD 1-0 CODE                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Systemic Lupus Erythematosus                      M32.9<br><input type="checkbox"/> Other: _____                                              ICD10 _____ |

| REQUIRED DOCUMENTATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Clinical/Progress Notes<br><input type="checkbox"/> Patient Demographics AND Insurance Information <input type="checkbox"/> Labs and Tests Supporting Primary Dx, including autoantibody testing (ANA, anti-dsDNA) for SLE<br><input type="checkbox"/> Hepatitis B Test Results: HBsAg<br><input type="checkbox"/> QuantiFERON Gold TB Test Results<br><input type="checkbox"/> Patient currently receiving same therapy at _____ Last dose: _____ |
| List Tried & Failed Therapies, including duration of treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 2)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| MEDICATION ORDERS**                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------|
| Dosing <input type="checkbox"/> Saphnelo 300mg infuse IV over 30 minutes every 4 weeks                               |
| Patient Weight = _____ kg                      Patient Height = ____ ft ____ in                                      |
| Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____ |

\*\*Patient weight is required for all weight based therapies - please indicate weight in kilograms.

| PREMEDICATIONS                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Acetaminophen 650mg PO prior to Saphnelo infusion<br><input type="checkbox"/> Diphenhydramine 25mg PO prior to Saphnelo infusion<br><input type="checkbox"/> Methylprednisolone 40mg slow IVP<br><input type="checkbox"/> Other: |

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

| PRESCRIBER INFORMATION |       |          |
|------------------------|-------|----------|
| Prescriber Name:       | NPI:  | Contact: |
| Phone:                 | Fax:  | Email:   |
| Prescriber Signature:  | Date: |          |

**Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com**

Fax completed form and ALL documentation to 804-554-5848

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