

**Site of Care**

- ☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

SAPHNELO (ANIFROLUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____
Patient Weight: _____ Patient Height: _____ Allergies: _____
Other Medications: _____

DIAGNOSIS (Provider must specify)

- ☐ Systemic Lupus Erythematosus, ICD10: _____
☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

- ☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

- ☐ Acetaminophen (Tylenol) 500 MG PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP
☐ Other: _____ Dose: _____ Route: _____
☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Saphnelo	☐ 300 mg	IV	☐ Every 4 weeks

- ☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____
Phone: _____ Fax: _____ Email Address: _____
Signature: _____ Date: _____