Saphnelo

(anifrolumab-fnia)

Infusion Order

CIVIC INFUSION

○ 249 Danbury Rd. Wilton, CT 06897
○ 400 Columbus Ave, Valhalla, NY 10595
○ 127 Washington Ave, North Haven, CT 06473
○ _____
Ph: 203-883-0038 Fax: 203-724-4838

Patient Name: _____ DOB: _____/_____/_____ M ○ F ○

Allergies: _____ Phone: _____

Diagnosis: _____ ICD- 10: _____

Please fax a copy of the following patient information:

☐ **Recent Progress Note** ☐ **Positive ANA titer, Anti-DsDNA, or Anti-Sm lab** ☐ **Herpes Zoster Vaccination Record**

Herpes Zoster Vaccination Date: _____/_____/_____ OR MD Signature Deferring Vaccination: _____

Positive ANA Titer test date: _____/_____/_____ Result: _____

Anti-DsDNA test date: _____/_____/_____ Result: _____ Anti-Sm test date: _____/_____/_____ Result: _____

PRE- MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ No Pre-med
☐ Solu- Medrol 125mg IVP
☐ Solu- Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
Other: _____

SAPHNELO ORDER

DOSAGE

○ 300mg IV

Patient Weight: _____ lbs / kg

Height: _____ft_____in

FREQUENCY

○ Every 4 weeks ***OR*** ○ Every _____ weeks

NOTES:

_____

Provider's Name: _____ Signature**:** _____

NPI: _____ Date: _____ Ph: _____ Fax: _____