

Saphnelo

(anifrolumab-fnia)

Infusion Order



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

Solu- Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu- Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

No Pre-med

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: _____