

anifrolumab-fnia (Saphnelo)



Provider Order Form rev. 9/14/2021

PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

LABORATORY ORDERS

- CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other: _____

PRE-MEDICATION ORDERS (OPTIONAL)

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg / 50mg PO / IV
 methylprednisolone (Solu-Medrol) 40mg / 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

- Anifrolumab-fnia** (Saphnelo) 300mg in 100ml 0.9% sodium chloride
- Dose: 300mg in 100ml NS
 - Route: intravenous
 - Frequency: once every 4 weeks
 - Infuse over 30 minutes
 - Flush with 0.9% sodium chloride at infusion completion
- Patient required to stay for 30-min observation post procedure
 Patient is NOT required to stay for observation time
 Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Provider Signature _____ Date _____

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- | | | | | |
|---------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> BAY AREA: 844-899-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> TAMPA: 844-946-0849 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
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