Provider Order Form

SAPHNELO (ANIFROLUMAB-FNIA)

Uptiv Health

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Systemic lupus erythematosus (SLE) M32. _____ ☐ Other: _____

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Saphnelo (Anifrolumab-Fnia), IV in 100 ml 0.9% sodium chloride	☐ 300 mg	☐ Every 4 weeks

Other: _____

Refills ☐ Zero ☐ 12 months ☐ ___ Order valid for 1 year unless otherwise stated.
☒ Infuse over at least 30 minutes.
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Shingles vaccination status

Provider Signature Date