



Anifrolumab (Saphnelo)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment:

- ☐ Systemic Lupus Erythematosus (SLE), organ or system involvement unspecified – M 32.10 ☐
- ☐ Endocarditis in systemic Lupus Erythematosus (SLE) – M32.11
- ☐ Pericarditis in Systemic Lupus Erythematosus (SLE) - M32.12
- ☐ Lung involvement in Systemic Lupus Erythematosus (SLE) - M32.13
- ☐ Glomerular disease in Systemic Lupus Erythematosus (SLE) - M32.14
- ☐ Tubulo-interstitial nephropathy in Systemic Lupus Erythematosus (SLE) - M32.15
- ☐ Other organ or system involvement in Systemic Lupus Erythematosus (SLE) - M32.19
- ☐ Other forms of Systemic Lupus Erythematosus (SLE) - M32.8
- ☐ Systemic Lupus Erythematosus (SLE) , unspecified - M32.9

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☒ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Other: _____

Infusion – Anifrolumab (Saphnelo) [J0491 : 1 MG = 1 unit]

- ☒ Anifrolumab (Saphnelo) 300 MG in 100 mL of 0.9% Normal Saline Solution INTRAVENOUS ONCE over 30 minutes using an infusion line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter. Repeat EVERY 4 WEEKS.

Infusion Reaction

- ☒ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

- ☒ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE: _____
10842512

TIME: _____

PHYSICIAN'S SIGNATURE