anifrolumab-fnia (Saphnelo)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐New Referral ☐Updated Order ☐Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐NKDA Allergies:

Therapy Status: ☐New to Therapy ☐Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐M32.14 Glomerular disease in systemic lupus erythematosus ☐M32.19 Other organ or system involvement in systemic lupus erythematosus

☐M32.8 Other forms of systemic lupus erythematosus ☐M32.9 Systemic lupus erythematosus, unspecified

☐M32.10 Systemic lupus erythematosus, organ or system involvement unspecified

☐Other:

PRIMARY MEDICATION ORDER

Anifrolumab-fnia (Saphnelo) 300mg IV in 100ml 0.9% sodium chloride every 4 weeks

• Infuse over 30 minutes
• Flush with 0.9% sodium chloride at infusion completion
• Refill for 12 months unless otherwise noted: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Saphnelo

☐acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐cetirizine (Zyrtec) 10mg PO
☐loratadine (Claritin) 10mg PO
☐famotidine (Pepcid) 20 mg IV
☐diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
☐methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

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

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐Arbor Infusion Fishers (317) 981-1772
☐Arbor Infusion Carmel (317) 981-1772