SAPHNELO® Infusion Form

Fax Referral To: 877-438-9380

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Systemic lupus erythematosus (SLE)

_____ Other: _____

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Recent Lab Results including any recent antibody testing results (i.e. ANA)

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **SAPHNELO® (anifrolumab-fnia)**

New Start:

300 mg per 100 ml Sodium Chloride 0.9% IV to infuse over 30 minutes every 4 weeks via pump with 0.2 or 0.22-micron filter. _____# Refills

Pre-Medication Orders: Acetaminophen: 650 mg PO 500 mg PO 325 mg PO
Diphenhydramine: 25 mg PO, 50 mg PO, 25 mg IVP, 50 mg IVP or
Fexofenadine 60mg or 180 mg, Cetirizine 10 mg, Loratadine 10 mg
Methylprednisolone 40 mg IVP 125 mg IVP or other mg IVP _____
Famotidine: 20 mg PO, 40 mg PO, 20 mg IVP, 40 mg IVP

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.