

Saphnelo (anifrolumab-fnia)

Provider Order Form rev. 5/20/2022



www.aleracare.com

ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

NKDA Allergies: _____ Weight lbs/kg: _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Therapy Change 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: _____

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

M32.9 Systemic lupus erythematosus

Other: _____

MEDICATION ORDER

Saphnelo (anifrolumab-fnia)

Dose: 300mg IV

Frequency: every 4 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

SPECIAL INSTRUCTIONS

Dose: _____ Route: _____ Frequency: _____

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order