Saphnelo Order Form (antifrolumab-fnia)

Fax To: 503-540-3105

PATIENT INFORMATION

Patient Name: ________________________________ DOB: __________ Phone: ______________ Sex: ☐ M ☐ F Ht:_____ Wt: _____ ☐ lbs ☐ kg

Primary Language: ____________________ Allergies: ____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE, if applicable)
☐ M32.9 Systemic Lupus Erythematosus, Unspecified
☐ Other: ____________________________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy
LAB RESULTS: Positive autoantibody results: i.e. Anti-dsDNA, Antinuclear Antibody (ANA), Anti-Smith

PRESCRIPTION

Pre-Medications
☐ Acetaminophen: 650 mg PO
☐ Cetirizine 10 mg PO
☐ Dexamethasone: ______ mg IV
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IV
☐ Other: ________________________________
☐ Acetaminophen: _____ mg PO
☐ Famotidine: _____ mg IV
☐ Loratadine 10 mg PO
☐ Methylprednisolone: _____ mg IV
☐ Ondansetron: 4 mg IV

Lab Orders
☐ CBC w/diff: every ________ ☐ weeks ☐ month
☐ CMP: every __________ ☐ weeks ☐ month
☐ Other: ________________________________

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Dose and Frequency (SELECT ONE)
☐ **IV**: infuse 300 mg every 4 weeks x 1 year

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose: ____________________________________

PRESCRIBING INFORMATION

Prescriber Name: ____ Signature: ____

Date: _______________ NPI #_________________________________ Specialty: ____

Office phone #: ____ Office Fax #: ____