Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Anifrolumab- fnia)

Saphnelo infusion orders

INFUSE ONE

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Systemic Lupus Erythematosus ☐ _____ Other

PRE-MEDICATIONS (optional)

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ (other)

Saphnelo (Anifrolumab- fnia) ORDERS

DOSAGE & FREQUENCY

☐ 300mg IV once every 4 weeks

☐ _____ Other

Patient Weight

_____ lbs

_____ kg

NOTES:

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____