Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

SAPHNELO MEDICATION ORDER

Patient's Name (Last, First, Middle) ______________________________ DOB ______________________

Patient's height in feet and inches ____________________ *Patient's weight in pounds*_________________________

■ **Diagnosis** *Please provide diagnosis and code to the highest possible level of specificity.*

☐ M32.10 Systemic lupus erythema., org or sys involv unsp
☐ M32.11 Endocarditis in SLE
☐ M32.12 Pericarditis in SLE
☐ M32.13 Lung involvement in SLE
☐ M32.14 Glomerular disease in SLE
☐ M32.15 Tubulo-interstitial nephropathy in SLE
☐ M32.19 Other organ or system involvement in SLE
☐ M32.8 Other forms of SLE
☐ M32.9 Systemic lupus erythematosus, unspecified

■ **Details Needed for Approval** *Please answer all applicable questions and provide supporting documentation.*

FOR NEW THERAPY

☐ Does the patient have moderate-to-severe or severe SLE? _____
☐ What is the patient's SLEDAI 2K score? _____ Alternatively, what is the patient's BILAG score? _____
☐ What is the patient's PGA score despite receiving standard SLE therapy? _____
☐ What medication is the patient currently taking for SLE? ____________________________
☐ Will the patient be concurrently using Saphnelo together with another biologic agent? _____ If Yes, which? ______________

FOR CONTINUING THERAPY

☐ Is the patient showing clinical benefit while on Saphnelo? _____ If Yes, please provide details in chart notes.
☐ Please provide documentation showing improvement versus baseline, such as SLEDAI 2K score, BILAG score and/or PGA score.
☐ There is absence of unacceptable toxicity from Saphnelo? _____

FOR ALL PATIENTS (in addition to the appropriate section above)

☐ Does the patient have severe CNS lupus? _____
☐ Does the patient have severe active lupus nephritis? _____
☐ Is the patient currently receiving therapy for any infection? _____ If Yes, what rx and what for? ______________________
☐ Will the patient be instructed not to have any live vaccines while taking Saphnelo? _____
☐ Please attach a list of which medications for SLE the patient has tried and failed and/or has contraindication for.
☐ Laboratory results for ANA, AntiodsFNA, Anti-Ro/SSA, anti-SLE, and/or anti-Smith antibodies should be provided.

■ **Medication Order**

☐ Saphnelo (anifrolumab-fnia) 300mg by IV every 4 weeks for _____ months.
Medication shall be added to a 100ml 0.9% NaCl infusion bag. The IV line shall have a 0.2 or 1.2 micron in-line filter attached. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including Diphenhydramine, Methylprednisolone, Albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider Signature: __________________________ Name: __________________ Date: ____________________

Address: ____

Phone: _______________ Fax: ________________ Indiv. NPI #: _____________ License: ________________

Best Contact Person in Office: ________________________ Direct Phone to Contact Person: _____________________

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.