Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Saphnelo® (anifrolumab-fnia) Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Systemic Lupus Erythematosus ICD-10 Code _____
☐ Other _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Provider Practice Notice: Ordering provider to screen patients for herpes zoster vaccination prior to therapy initiation.

Authorized Treatment Duration

☑ Every 4 weeks x 12 months

Infusion Monitoring

☑ Vital Signs
every 30 min, Prior to infusion, every 30 minutes during infusion, and prior to discharge
Pre-Medications - Administer 30 minutes before vedolizumab dose if required

Pre-Medications

Tylenol
☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before anifrolumab dose

Benadryl
☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before anifrolumab dose
☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before anifrolumab dose

SOLU-Medrol
☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before anifrolumab dose

Saphnelo

☑ *300 mg, IV Piggyback*
Comments: Prepared in 100ml sodium chloride 0.9%, infuse over 30 minutes, with low-protein binding 0.2 micron in-line filter.

☑ Flush Intermittent Normal Saline
25 mL, IV Piggyback, Once
Comments: for flushing IV tubing after intermittent IV piggyback infusion

☑ Communication Order
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Saphnelo® (anifrolumab-fnia) Treatment Plan

☑ Communication Order

Inquire with patient prior to infusion for active infection, or ongoing infection treatment (ABX therapy, antifungal therapy, etc.). If positive notify provider and hold infusion.

☑ Notify Provider

for Fever/Chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticarial, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Day 0, 14, 28)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

☐ Biosimilar Substitution **NOT** permitted