Saphnelo®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Systemic Lupus Erythematosus [SLE] (M32.0-M32.9), ICD10 _____

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Saphnelo® (anifrolumab)	300 mg	Infuse IV over 30 minutes every 4 weeks x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is positive for autoantibodies relevant to SLE.

☐ The patient is receiving a stable standard of care treatment for active SLE.

Please specify current therapy:

☐ Glucocorticoids

☐ Antimalarials

☐ Immunosuppressants

LAB AND TEST RESULTS (required)

☐ Autoantibody test:

☐ Anti-nuclear antibody (ANA)

☐ Anti-double-stranded DNA (anti-dsDNA)

☐ Anti-Smith antibody (anti-Sm)

☐ Antiphospholipid antibody

☐ Complement proteins

☐ Other: _____

☐ Other: _____

PRIOR FAILED THERAPIES (including corticosteroids, antimalarials, immunosuppressants, other biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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