DEHESA DERMATOLOGY

Dehesa Dermatology
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https://dehesadermatology.com

ANIFROLUMAB (SAPHNELO®) INFUSION ORDER

Patient Information

Patient Name: _____

DOB: _____

Patient Height: _____
Patient Weight (kg): _____

Address: _____
_____

Phone: _____

Diagnosis: _____
ICD-10 Code: _____

Attach:
☐ Patient demographics
☐ Copy (front & back) of insurance card(s)
☐ Most recent clinical notes

Required (Results must accompany order)

☐ Tuberculosis Screening (QuantiFERON-TB Gold or TST)
☐ Hepatitis B Surface Antigen (HBsAg)
☐ Hepatitis B Core Antibody (Total Anti-HBc)
☐ Hepatitis C Screening
☐ Baseline CBC
☐ Baseline CMP

Provider confirms:
☐ No active infection
☐ Vaccinations reviewed (avoid live vaccines during treatment)
☐ No contraindication to anifrolumab therapy

Medication Order

☐ **Anifrolumab-fnia (SAPHNELO®)** 300 mg IV

Dosing Regimen

☐ 300 mg IV every 4 weeks
☐ Other: _____

Pre-Medications (Administer if clinically indicated or prior infusion reaction)

☐ None
☐ Acetaminophen 650 mg PO once
☐ Diphenhydramine 25–50 mg PO or IV once
☐ Methylprednisolone _____ mg IV once

PRN

☐ Diphenhydramine 25–50 mg IV PRN
☐ Methylprednisolone 125 mg IV PRN
☐ Famotidine 20 mg IV PRN
☐ Zofran 4mg IV
☐ Hydralazine 5-10mg
☐ Epinephrine 0.3 mg IM PRN anaphylaxis
☐ Albuterol 2.5 mg nebulized PRN bronchospasm
☐ Normal Saline IV bolus PRN hypotension
☐ Call ordering provider for moderate/severe reaction.

Additional Instructions

Ordering Physician:

Printed Name: _____

Signature: _____Date: _____

Contact Person: _____

Phone: _____Fax: _____

FAX ORDER TO 559.234.6334