

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required) Please complete 2nd and 3rd digits to complete ICD-10 for billing

M32.9 Systemic Lupus erythematosus, unspecified
Other: _____, ICD-10 _____

INFUSION ORDERS

Table with 3 columns: MEDICATION, DOSE, DIRECTIONS/DURATION. Row 1: Saphnelo® (anifrolumab-fnia), 300mg, Infuse IV over 30 minutes every 4 weeks x 1 year

Is patient currently receiving therapy above from another facility? NO YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
PRE-MEDICATION ORDERS: No premeds ordered at this time Diphenhydramine 25mg PO
Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

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

TEST RESULTS (required)

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
Annual TB screening to be done by: Infusion Center Referring Physician
Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizumab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

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