INTRAMED Plus
infusion services

SAPHNELO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Systemic lupus erythematosus, unspecified ICD-10 Code: M32.9

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
  - Include any labs or other diagnostic results to support diagnosis
  - Medication List
  - Notes on any previously trialed and failed therapies

Patient Weight: _____ lbs.

Height: _____ in.

SAPHNELO® (anifrolumab-fnia) J Code: J0491

4. Drug Order:

Administer 300 mg SAPHNELO IV every 4 weeks _____# Refills (Recommend 11 Refills)

Pre-Medication Orders: _____

*No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**