Northwest Rheumatology Associates, P.C.
9555 SW Barnes Road - Suite 150 – Portland, Oregon 97225
Telephone: (503) 297-3384 - Fax: (503) 297-0863
www.nwrheumatology.org

Anifrolumab-fnia (Saphnelo) Order Form

Patient Name: _____ DOB: _____ Date: _____

☐ Patient weight _____

☐ Patient demographics, (address, phone)

☐ Copy front and back of all insurance cards

☐ Diagnosis _____ ICD-10 Code: _____

***REQUIRED* Referring provider to confirm the following:**

☐ Patient has been appropriately screened for Hepatitis B, Hepatitis C infection and there is no contradiction to the treatment. Please send the results with the order.

☐ Patient has been appropriately screened for Tuberculosis infection and there is no contradiction to the treatment. Please send the results with the order.

Prescription orders: Please provide dose and frequency interval below

☐ Anifrolumab-fnia (Saphnelo) 300 mg in sodium chloride 0.9%, intravenous, ONCE, every 4 weeks, over 30 minutes.

**Order expires one calendar year from signed date at which point new order will be needed.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment.

☐ Acetaminophen (TYLENOL) tablet, 500 mg, oral, ONCE, every visit

☐ Loratadine (CLARITIN) tablet, 10 mg, oral, ONCE every visit

***REQUIRED* Please select what best describes your patient.**

Mobility status
- ❍ Independent
- ❍ Walker
- ❍ Wheelchair
- ❍ Fully dependent
- ❍ No

Bariatric needs
- ❍ Yes, briefly describe
- ❍ No

Behavioral/ Cognitive or Memory concerns
- ❍ Yes, briefly describe
- ❍ No

Ordering physician signature: _____

Ordering physician printed name: _____

Ordering physician phone number: _____

Ordering physician fax number: _____

Please note all boxes must be checked off for us to schedule your patient for treatment.
Please fax this information to (503) 297-0863 Attn: Patient Resource Team
Please call with any questions at (503) 297-3384