**Nevada Infusion**
**Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511**
**Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706**
**PH: 775-453-0667 | Fax: 775-470-8478**

# Saphnelo Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

**DIAGNOSIS**

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

**ORDER FOR SAPHNELO (ANIFROLUMAB-FNIA):**

- ☐ **300mg IV every 4 weeks x 1 year**
- ☐ **Other Dose:**_____ **Frequency:**_____x 1 year

**PRE-MEDICATIONS:**

- ☐ Pre-Medications may be PRN (as needed)
- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

**MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:**

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

**PROVIDER INFORMATION:**

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 03/2026

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Patient Name: _____ DOB:_____

**Please Include Required Documentation for Expedited Order Processing & Insurance Approval:**

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy:

☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)?

☐ Yes OR ☐ No

If yes, which drug(s)? _____

☐ Has the patient tried and failed Benlysta therapy?

☐ Yes OR ☐ No

☐ Include labs and/or test results to support diagnosis

**Additional REQUIRED Information:**

☐ ANA, Anti-dsDNA, Anti-Ro/SSA, and/or anti-Smith antibodies (please attach results)

☐ Tried and failed medications (please attach)

☐ Other medical necessity: _____

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