McLeod Health

Anifrolumab-fnia (Saphnelo) Treatment Plan

Patient Name:		DOB:		
Height (cm):	Weight (kg):	Allergies:		
Patient Primary Phone I	Number:			
Diagnosis (select one):				
☐ M32.9 Systemic lupus	s erythematosus, unspecified			
☐ Other: ICD 10 Code: _	Diagnosis	Description:		
<u>Pre-Medications:</u> **adı	ministered 30 minutes prior to i	infusion**		
□ None				
☐ Acetaminophen 650 r	mg PO			
☐ Diphenhydramine:	Dose: ☐ 25 mg ☐ 50 mg	Route: ☐ PO or ☐ IVP		
☐ Methylprednisolone:	Dose: \square 40 mg or \square 125 mg	Route: IVP		
☐ Famotidine:	Dose: 20 mg	Route: ☐ PO or ☐ IVPB		
☐ Other (include drug, o	dose, and route):			
Drug Orders:				
 Anifrolumab (Saphnel weeks 	o) (J0491) 300 mg per 50 mL So	odium Chloride 0.9% IV to infuse over 30 minutes once ev	very 4	
Order Duration: Twelve months unless otherwise specified (Other:				
Standing Orders:				
	tocol (CPOE-1396) will be activa I and physician notified.	ated if any hypersensitivity reaction occurs, including ana	phylaxis.	
Physician Signature:		Date:	_	
Physician Name:		Phone:	_	

Pre-Screening Requirements:

• Lab results and/or testing to confirm diagnosis

Previous Therapies:

• For new patient referrals, please send history	and physical and most recent pl	nysician note with completed plan		
If patient has previously received anifrolumab	at another facility, please provi	de last date received:		
If patient has previously received another bio and the last date received:		e name:		
Insurance Information:				
Insurance Plan Name:				
Insurance Identification Number:				
Insurance Customer Service Contact Number:				
Preferred Treatment Location				
☐ McLeod Regional Medical Center (Florence)	☐ McLeod Health Loris	☐ McLeod Health Cheraw		
☐ McLeod Health Seacoast (Little River)	☐ McLeod Health Dillon	☐ McLeod Health Clarendon (Manning)		

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.