



**Atrium Health Infusion  
Center**

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord <b>Fax:</b> 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Pineville <b>Fax:</b> 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Southpark <b>Fax:</b> 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Huntersville <b>Fax:</b> 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC <b>Fax:</b> 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC <b>Fax:</b> 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC <b>Fax:</b> 704-512-5390

**Saphnelo® (anifrolumab-fnia) Infusion Order** (Revised 10/20/2025)

All orders with a √ will be placed.

<b>Patient Demographics:</b>		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) <input type="checkbox"/> NKDA		
<b>Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)</b>		
<input type="checkbox"/> M32.9 - Systemic Lupus Erythematosus	<input type="checkbox"/> Other:	
<b>Required Documentation: (required prior to scheduling)</b>		
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:  <input type="checkbox"/> No Washout Needed	
Copy of Insurance Card (front and back)		
Most Recent Labs (must include labs pertinent to medication ordered)		
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:	
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.	
Diagnostic Studies Pertinent to Medication Ordered	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Treatment Parameters:</b>		
Hold treatment and notify provider IF: <input checked="" type="checkbox"/> - Temperature is GREATER THAN 100oF; <input type="checkbox"/> - Patient complains of symptoms of acute viral or bacterial infection; <input type="checkbox"/> - Patient is taking an antibiotic for current infection.		
<b>Nursing Communication:</b>		
<input checked="" type="checkbox"/> Start PIV/Access CVC and flush device per approved Atrium Health protocol.		
<input checked="" type="checkbox"/> Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.		
<input checked="" type="checkbox"/> Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.		
<b>Pre-Medications: (Administer all pre-medications 30mins prior to treatment)</b>		
<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV ONCE		
<input type="checkbox"/> Loratadine (Claritin) 10mg PO ONCE		
<b>Infusion Therapy:</b>		
<input checked="" type="checkbox"/> Anifrolumab-fnia (Saphnelo) 300mg IV every 4 weeks. Administer over 30 minutes.		
<b>Supportive Care Medications:</b>		
<input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.		
<input checked="" type="checkbox"/> Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.		
<input checked="" type="checkbox"/> Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.		
<b>Hypersensitivity Protocol:</b>		
<input checked="" type="checkbox"/> Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.		
<b>Prescriber Information:</b>		
Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	
<b>Physician Signature: (Order expires 12 months from date of signature ) No Stamp Signatures Accepted</b>		
Signature:	Date:	