Infusion Center
Kennebunk ▪ Portsmouth ▪ Scarborough ▪ Topsham
Phone: 207-303-3225 Fax:207-692-2473

## Saphnelo (anifrolumab) IV - J0491

**Patient Name:**______________________________________ **DOB:**

Diagnosis: _______________________________ Diagnosis Code:_______________

Height: _____(cm) Actual Weight: ____(kg) Allergies: _________________________

Please list any premeds needed here: __________________________________________

________________________________________________________________________

☐ **Saphnelo (anifrolumab) 300 mg IV infused over 30 minutes every 4 weeks**

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____________________________________________

Provider Signature: __________________________________________ Date: __________

Phone: _______________ Fax: _______________ Pager: _______________