St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Anifrolumab-fnia (SAPHNELO)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Infusion reactions and Hypersensitivity reactions, including severe hypersensitivity reactions (i.e., anaphylaxis and angioedema), have been reported.
3. Live or live attenuated vaccines should not be given concurrently.
4. Avoid initiating treatment in patients with a significant active infection until the infection resolves or is adequately treated.

NURSING ORDERS:

1. TREAMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
2. Infuse using a sterile, low-protein binding 0.2 micron in-line filter. Flush infusion set with 25 mL of NS upon completion. Do not co-administer other medicinal products through the same infusion line.
3. HYPERSENSITIVITY/INFUSION REACTION - Monitor for infusion-related reactions for 30 minutes after completion of the first infusion. If no previous infusion reactions, monitoring not required for subsequent doses. Monitoring recommended for previous infusion reactions, contact provider for guidance.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
5. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.

PRE-MEDICATIONS (optional):

Optional Pre-Medications. Consider for patients with a history of hypersensitivity or infusion reactions. Administer 30 minutes prior to each infusion. Select the pre-medications to be given.

Select	Medication	Dose	Route	Frequency
☐	Acetaminophen (Tylenol)	650 mg	PO	Once

☐	Diphenhydramine (Benadryl)	25 mg	☐ PO ☐ IV	Once
☐	Cetirizine (Zyrtec)	10 mg	PO	Once
☐				

MEDICATIONS:

☑ Anifrolumab-fnia Infusion: Administer Anifrolumab-fnia (Saphnelo) 300 mg IV every 4 weeks. Dilute in 100mL 0.9% Sodium Chloride and administer over 30 minutes.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

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Plan will expire 1 year after signature date at which time a new order will need to be placed