

Please fax all pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Saphnelo® (anifrolumab-fnia)

EVERNORTH
HEALTH SERVICES

Four simple steps to submit your referral.

1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: Male Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line: _____

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Has the patient been treated previously for this condition? Yes No

Is patient currently on therapy? Yes No Please list all therapies tried/failed: _____

_____ Patient wt _____ Date wt obtained _____

NKDA Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

INFUSION LOCATION: Patient's home Healthcare facility

Medication	Strength/Formulation	Directions	Quantity/Refills	Ship to
Saphnelo® (anifrolumab-fnia)	300mg single dose vial/INJ 2mL	Infuse 300mg intravenously every 4 weeks	Dispense: 1 vial Other _____ Refill x 1 year unless noted otherwise. Other _____	NOTE: Per Accredo Nursing, naïve patients must receive 3 doses in a controlled setting before starting home infusion. First 3 doses for naïve patients: Unknown Office Infusion Clinic Patient is not naïve to therapy and has received at least 3 doses in a controlled setting
Other			1-month supply 3-month supply Other _____ Refills _____	

Required medication and supplies for home infusion (please complete this section for home infusions only)	Quantity/Refills
<p>Premedication orders: _____</p> <p>Infusion method: Gravity unless otherwise instructed (Prefer Pump)</p> <p>Fluids for administration and reconstitution (please strike through if not required) NS 0.9% 100mL NS 0.9 % 50mL for post flush NS 0.9% Flush (if central venous access, sterile flush will be provided) Choose administration access: Peripheral access Central venous access If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. Follow with heparin 100units/mL 5mL final flush If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed</p> <p>Hypersensitivity/Anaphylaxis: Stop infusion Medicate with: Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis Other _____</p> <p>Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.</p>	Send quantity and refills sufficient for medication days supply.

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
 If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE _____
 Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.