ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

BENLYSTA (BELIMUMAB) INFUSION ORDERS

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

☐ New ☐ Restart ☐ Continuing Next treatment date/Date needed by: _____

Special Pharmacy requested: _____

Special Pharmacy ship to: ☐ Patient Address (BENLYSTA SC only) ☐ Prescribing Physician's office ☐ Administering Physician's office ☐ HOPD ☐ ASOC

MEDICATION	STENGTH/FORM	QTY	DIRECTION FOR ADMINISTRATION	REFILL
BENLYSTA SC	200 mg in a 1-ml single dose autoinjector (box of 4)			
BENLYSTA SC	200 mg in a 1-ml single dose prefilled glass syringe (box of 4)			
BENLYSTA IV	120 mg in a 5-ml single-use vial			
BENLYSTA IV	400 mg in a 20ml single-use vial			

JCode: J0490 **Diagnosis** ☐ Systemic Lupus Erythematosus ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of last ANA Test:_____ ☐ Copy of documentation attached

Labs: Required to be drawn by: ☐ **Infusion Clinic** ☐ **Referring Physician**

Labs Orders: _____

BENLYSTA ORDERS

BENLYSTA
☐ Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter
☐ Maintenance: 10mg/kg IV every 28 days

Protocol
☐ Tylenol 1000mg PO, **Please choose one antihistamine.**
☐ Cetirizine 10 mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10 mg PO

Additional
☐ Solu-Medrol _____ mg IVP
☐ Solu-Cortef _____ mg IVP

Additional Orders/Comments:

Hypersensitivity/Anaphylaxis Response Protocol PRN

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.