Benlysta (belimumab) Infusion orders



Patient Demographic Information (Or Attach Face Sheet from Patient Chart)														
Patient Name				DOB		Gender	Mal	e 🗌	Female	• 🗆 '	Weight		lbs 🗌 k	kg 🗌
SSN		Phone			Allergies									
Address					City		Stat	e		2	Zip Cod	e		
Patient Insurance Information (Or Attach Face Sheet from Patient Chart)														
Primary Insura	nce			Name o	f the Insure	d				Relat	ionship			
Member ID#				Group	#		Ir	nsuran	ice Pho	ne #				
Secondary Rx (Carrier			1		Rx ID	#			Rx Gr	oup #			
Medical Inf	ormati	on												
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	DIREC		FOR AD	MINIST	RATION	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/Pro	gress No	tes, Labs, 1	ests sup	porting	orimary dia	gnosis at	tache	d						
Date of last ANA Test: 🗌 Copy of documentation attached														
Labs: Required to be drawn by: 🗌 Infusion Clinic 🛛 Referring Physician														
Labs Orders:														
BENLYSTA	ORDE	RS												
BENLYSTA 🔲 Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter Maintenance: 10mg/kg IV every 28 days														

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BENLYSTA ORDERS

Protocol	 Cetirizir Diphen 	 Tylenol 1000mg PO, Please choose one antihistamine. Cetirizine 10 mg PO Diphenhydramine 25mg PO Additional Solu-Medrol mg IVP Loratadine 10 mg PO Solu-Cortef mg IVP 										
Additional (Orders/Comm	ents:										
Hypersensitivity/Anaphylaxis Response Protocol PRN												
Prescriber Insurance Information												
Prescriber Name		NPI#		Office #					Fax #			
Address					City		:	State			Zip Code	
	rize DeliverIt s	pecialty pharmacy to ini	tiata Driar	Author	izationa	on my bobalf	:	Date				
		рестату рнаннасу со ни	tiate Phot	Author	Izations	Soff filly Defiall	•					
_	vispense as wr			Author	nzations	Soff frig Defiait		Presc	riber	r's Signa	ture	