

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



(belimumab)

BENLYSTA infusion orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Systemic Lupus Erythematosus</p> <p><input type="checkbox"/> _____ (other)</p> <p><input type="checkbox"/> _____ (other)</p> <p>PRE-MEDICATION</p> <table><tr><td><input type="checkbox"/> Tylenol 1000mg PO</td><td><input type="checkbox"/> Solu-Medrol 125mg IVP</td></tr><tr><td><input type="checkbox"/> Diphenhydramine 25mg PO</td><td><input type="checkbox"/> Solu-Cortef 100mg IVP</td></tr><tr><td><input type="checkbox"/> Cetirizine 10mg PO</td><td><input type="checkbox"/> Diphenhydramine 25mg IVP</td></tr><tr><td><input type="checkbox"/> _____ (other)</td><td><input type="checkbox"/> _____ (other)</td></tr></table>	<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP	<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP	<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP	<input type="checkbox"/> _____ (other)	<input type="checkbox"/> _____ (other)
<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP							
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP							
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP							
<input type="checkbox"/> _____ (other)	<input type="checkbox"/> _____ (other)							

<p>BENLYSTA ORDERS</p> <p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p> <p>DOSAGE:</p> <p><input type="checkbox"/> 10mg/kg IV</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency:</p> <p><input type="checkbox"/> Dose at weeks 0,2, and 4, then every 4 weeks</p> <p><input type="checkbox"/> Dose every 4 weeks</p> <p><input type="checkbox"/> Total dosage: _____</p>
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<p>NOTES/ADDITIONAL COMMENTS:</p>
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ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____