

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



(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:

DIAGNOSIS *Please provide ICD-10 code*

_____ Systemic Lupus Erythematosus

_____ (other)

_____ (other)

PRE-MEDICATION

<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)

BENLYSTA ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

10mg/kg IV

Other _____

Frequency:

Dose at weeks 0,2, and 4, then every 4 weeks

Dose every 4 weeks

Total dosage: _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____