



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

BENLYSTA ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

M32.9 Systemic lupus erythematosus, unspecified

M32.10 Systemic lupus erythematosus, organ or system involvement unspecified

Other _____

DRUG:

Loading doses: 10mg/kg IV at weeks 0, 2, and 4 then every 4 weeks

Maintenance only: 10mg/kg IV every 4 weeks

Other _____

PREMEDICATION ORDERS: *not required by PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____