



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      M32.14 Lupus, nephritis

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:**

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

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

Methylprednisolone:  62.5mg IVP     125mg 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: \_\_\_\_\_