BENLYSTA (BELIMUMAB) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of prescription/medical card(s) (front and back).

Medical Information

J Code: J0490 Diagnosis: ☐ Systemic lupus erythematosus ICD-10 Code: _____

☐ Other ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

Date of Last ANA Test: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

Benlysta Orders

Benlysta

☐ Initial Dose: 10 mg/kg IV at days 0, 14 and 28, then every 28 days thereafter

☐ Maintenance: 10 mg/kg IV every 28 days

Protocol: **Tylenol 1000 mg PO, *please choose one antihistamine:***

☐ Cetirizine 10 mg PO

☐ Diphenhydramine 25 mg PO

☐ Loratadine 10 mg PO

Additional:

☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ **Physician Name:** _____ **Date:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other: _____

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