



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, <i>please choose one antihistamine:</i>	Additional:
Cetirizine 10 mg PO	Solu-Medrol _____ mg IVP
Diphenhydramine 25 mg PO	Solu-Cortef _____ mg IVP
Loratadine 10 mg PO	
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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