



BENLYSTA (belimumab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
 6. Tried/Failed Therapies 7. ANA or anti-dsDNA Labs 8. PGA Score _____ SLEDAI Score _____

PRIMARY DIAGNOSIS

M32.10 Systemic Lupus Erythematosus, organ or system involvement unspecified M32.14 Glomerular disease in Systemic Lupus Erythematosus
 M32.19 Other organ or system involvement in Systemic Lupus Erythematosus M32.8 Other forms of Systemic Lupus Erythematosus
 M32.9 Systemic Lupus Erythematosus, unspecified Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds for Benlysta
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Initial/Reload: Benlysta 10mg/kg IV at weeks 0, 2, 4, then every 4 weeks thereafter Maintenance: Benlysta 10mg/kg IV every 4 weeks
 Other _____ F IRST DOSE?: Yes No
 Refill x12 months unless otherwise noted _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

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PROVIDER SIGNATURE _____ DATE _____