

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

- | | |
|---|--|
| <input type="checkbox"/> M32.10 Systemic Lupus Erythematosus, organ or system involvement unspecified | <input type="checkbox"/> M32.14 Glomerular disease in Systemic Lupus Erythematosus |
| <input type="checkbox"/> M32.19 Other organ or system involvement in Systemic Lupus Erythematosus | <input type="checkbox"/> M32.8 Other forms of Systemic Lupus Erythematosus |
| <input type="checkbox"/> M32.9 Systemic Lupus Erythematosus, unspecified | <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Initial/Reload: Benlysta 10mg/kg IV at weeks 0, 2, 4, then every 4 weeks thereafter | <input type="checkbox"/> Maintenance: Benlysta 10mg/kg IV every 4 weeks |
| <input type="checkbox"/> Other _____ | FIRST DOSE?: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Refill x12 months unless otherwise noted _____ |

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

X

PROVIDER SIGNATURE _____ DATE _____