Horizon Infusions

Benlysta (belimumab)

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Perrysburg
- ☐ Springfield
- ☐ Toledo
- ☐ Warren
- ☐ Crestview Hills (NKY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Active Lupus Nephritis (_____) ☐ Active Systemic Lupus Erythematosus (_____) ☐ Other _____

5. PRESCRIPTION INFORMATION (*requires a new order every 12 months*)

BENLYSTA

Intravenous Dosage for Adult and Pediatric Patients with SLE or Lupus Nephritis:

☐ 10mg/kg at 2-week intervals for the first 3 doses and at 4-week intervals thereafter. Reconstitute, dilute, and administer as an intravenous infusion over a period of 1 hour. **Consider prophylactic premedication for infusion and hypersensitivity reactions.*

Subcutaneous Dosage for Adults with SLE:

☐ 200mg once weekly

Subcutaneous Dosage for Pediatric Patients with SLE:

☐ Weighing ≥ 40kg: 200mg once weekly

☐ Weighing 15kg to less than 40kg: 200mg once every 2 weeks

Subcutaneous Dosage for Adults with Lupus Nephritis:

☐ 400mg (two 200mg injections) once weekly for 4 doses, then 200mg once weekly thereafter

☐ Vital signs, hydration and anaphylaxis mgmt per HI protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV

☐ Prednisone _____ mg PO

☐ Other _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Prednisone _____ mg PO

☐ Other _____

6. LABS

☐ CBC w/ Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

☐ Quantiferon TB Gold, annually, last completed ***(date)***: _____

☐ Other (***specify***):_____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE **DATE**