



Benlysta Order Form

Select patient referral location: **Akron** **Athens** **Blue Ash** **Cleveland** **Columbus** **Crestview Hills**
 Dayton **Mansfield** **Perrysburg** **Springfield** **Toledo** **West Cincinnati**

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

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1. PATIENT INFORMATION

Name:	DOB:
Home 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. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

☐ Severe Active Lupus Nephritis (_____)	☐ ICD 10 (_____)
☐ Severe Active Central Nervous System Lupus (_____)	☐ Other (specify): _____

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

BENLYSTA

- ☐ Initial: Administer 10mg/kg IV at week 0, 2 and 4
☐ Maintenance: Administer 10mg/kg IV q 4 weeks
☐ Administer 200mg subq once weekly

- ☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
☐ 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 PO
☐ 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