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

Fax completed form to (724) 240-1586
Phone (724) 510-3702

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**