

**Site of Care**

- ☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

BENLYSTA (BELIMUMAB) ORDER FORM**PATIENT INFORMATION**

Patient Name: _____ DOB: _____ Mobile Number: _____
Patient Weight: _____ Patient Height: _____ Allergies: _____
Other Medications: _____

DIAGNOSIS (Provider must specify)

- ☐ Systemic Lupus Erythematosus, ICD 10: _____
☐ Other: _____

PRE-MEDICATION

- ☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) ____mg IVP
☐ Other: _____ Dose: _____ Route: _____
Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Benlysta	☐ 10 mg/kg	☐ IV	☐ Every 2 weeks x 3 doses, then every 4 weeks ☐ Every 4 weeks

- ☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS**PROVIDER INFORMATION**

Provider Name: _____ Provider NPI: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Signature: _____ Date: _____

Prior to treatment – ensure the following information is complete and attached with referral:

- ☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

Order valid for 1 year from date of signature unless otherwise specified here: _____