Phone: (833) 394-0600 Fax: (833) 996-4888

Benlysta IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, ☐ Severe active SLE ☐ Severe active CNS SLE ☐ NA

Copy of Benlysta Gateway Authorization Form attached ☐ Yes ☐ No
Is adequate form of birth control being used? ☐Yes ☐ No ☐ NA
What is patient SELENA-SLEDAI score prior to starting Benlysta? _____
Lupus nephritis: Does patient have active disease with renal biopsy (III-V)? ☐Yes ☐ No, eGFR <30 ☐Yes ☐ No

In the past year, what medications for the above diagnosis has the patient tried, failed or is currently taking?

Drug	Dose	Dates of use

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ _____

Pre-Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No
	Hydrocortisone IV	_____ mg	☐Yes ☐ No

Benlysta (belimumab) IV

☐ **10mg/kg** ☐ _____mg/kg

Frequency: ☐ **Initial dosing every 2 weeks for 3 doses THEN every 4 weeks**
☐ **q4wks**

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: _____