AYSA
THERAPEUTICS INFUSION CENTER

BENLYSTA (BELIMUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J0490 Diagnosis: ☐ Systemic Lupus Erythematosus ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of last ANA Test: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

BENLYSTA ORDERS

Benlysta

☐ Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter

☐ Maintenance: 10mg/kg IV every 28 days

Protocol:

☐ **Tylenol 1000mg PO, *please choose one antihistamine:***

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10mg PO

Additional:

☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____