



**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: \_\_\_\_\_

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