# BENLYSTA® Infusion Form

**Fax Referral To:**
**877-438-9380**

CONTINUUM Health

## PREVIOUS ADMINISTRATION

**Please provide the following information:** Last Infusion Date: _____ Next Infusion Date: _____

## Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ○ N ○ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

***Primary Diagnosis:***
_____ Systemic lupus erythematosus (SLE)
_____ Lupus Nephritis
_____ Other: _____

**Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Recent Lab Results including any recent antibody testing results (i.e. ANA)**

## Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

## Medication Order

***Medication:*** **BENLYSTA® (Belimumab)**

☐ ***New Start:***
Administer 10 mg/kg (_____ mg) IV on Week 0, Week 2, Week 4 and then every 4 weeks thereafter

_____# Refills (Recommend 8 Refills)

☐ ***Maintenance Regimen:***
Administer 10 mg/kg (_____ mg) IV every 4 weeks

_____# Refills (Recommend 8 Refills)

***Pre-Medication Orders:*** No Pre-medications are recommended based on manufacturer guidelines.

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)**
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date