BENLYSTA
(belimumab)

FLEXCARE
INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name: Patient's Phone Number:

Date of Birth: Address:

Allergies: See List ☐ NKDA ☐   City, State, Zip:

Weight:_____lbs or _____kg   Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card   • History & Physical   • Patient Demographics   • Most Recent Labs   • Medication List
• Tried/Failed Therapies   • ANA or anti-dsDNA Labs

• PGA Score (Please include documentation) _____   • SLEDAI Score_____

PRIMARY DIAGNOSIS

☐ M32.10 Systemic lupus erythematosus, organ or system involvement unspecified

☐ M32.14 Glomerular disease in systemic lupus erythematosus

☐ M32.19 Other organ or system involvement in systemic lupus erythematosus

☐ M32.8 Other forms of systemic lupus erythematosus

☐ M32.9 Systemic lupus erythematosus, unspecified

☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol, there are no recommended standard pre-meds for Benlysta
☐ Provider Prescribed: _____
_____

PRIMARY MEDICATION ORDER

☐ Initial/Reload: Benlysta 10mg/kg IV at Weeks 0, 2, 4, then every 4 weeks thereafter
☐ Maintenance: Benlysta 10mg/kg IV every 4 weeks
☐ Other:_____

First Dose: ☐ Y ☐ N   ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC   ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____   _____
Provider Signature   Date