

BENLYSTA(belimumab)☐ New Prescription/Referral☐ Prescription Refill

of Refills:

Rx:Patient Name:Patient Weight:kgDOB:**BENLYSTA:**

- ☐ Initial: 10 mg/kg IV q2Weeks x 3 doses, THEN
- ☐ Maintenance: 10 mg/kg IV q4Weeks
- ☐ 400-mg dose (two 200-mg injections) SC qWeek x 4 doses, THEN
- ☐ 200 mg SC qWeek

Other Orders:**Pre-Medication: (30 mins prior)**

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:

- ☐ Tylenol _____mg PO
- ☐ 650mg ☐ 975mg

☐ Benadryl _____mg

- ☐ 25mg ☐ IV
- ☐ 50mg ☐ PO

ANA Kit Protocol:☐ OK to use**Dx:**

- ☐ Systemic Lupus Erythematosus (M32.9)
- ☐ Others:

Physician Signature

NPI#:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Email:

Fax:

Other:

Office Mailing Address:

**Please include
the following**☐ Patient demographics☐ Insurance attached☐ Diagnosis (supporting)☐ History and Physical☐ Lab Results☐ Clinical progress notes☐ Medication List☐ Other Test Results