Benlysta

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*** Please include the following to expedite the order.** Demographics, Insurance Information, Current CBC & CMP, H&P Relevant to the Diagnosis, Current Medications, TB Results

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ M32.9 ☐ M32.15

Other Dx/ICD10: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PREMEDS

☐ No Premeds

BENLYSTA IV DOSE:

Date of Last Treatment, if Continuation: _____

Dose: _____ (10 mg/kg) Route: ☑ IV Start Date of Infusion: _____

Loading Dose: every 2 weeks x 3 doses (days 0, 14, 28) then every 4 weeks

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Smart Choice Infusion is authorized to administer generic or biosimilar.