DELIVERIT PHARMACY
Infusion & Specialty

BENLYSTA (BELIMUMAB) Infusion Orders

T: 832.939.8137 Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478 F: 832.939.8128

PATIENT INFORMATION

Patient Name: _____ Social Sec #: _____ Weight: ____ lbs

D.O.B: _____ Sex: Male ____ Female _____ Height: ____ lbs

Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

☐ New ☐ Restart ☐ Continuing Next treatment date/Date needed by:

Special Pharmacyrequested:

Special Pharmacy ship to: ☐ Patient Address (BENLYSTA SC only) ☐ Prescribing Physician's office ☐ Administering Physician's office ☐ HOPD ☐ ASOC

MEDICATION	STRENGTH/FORM	QTY	DIRECTIONS FOR ADMINISTRATION	REFILL
BENLYSTA SC	200 mg in a 1-ml single dose autoinjector (box of 4)			
BENLYSTA SC	200 mg in a 1-ml single dose prefilled glass syringe (box of 4)			
BENLYSTA IV	120 mg in a 5-ml single-use vial			
BENLYSTA IV	400 mg in a 20ml single-use vial			

JCode: J0490 Diagnosis ☐ Systemic Lupus Erythematosus ICD-10 Code:_____

☐ Other:_____ICD-10 Code:_____

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of last ANA Test:_____ ☐ Copy of documentation attached

Labs: Required to be drawn by:

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 10 mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10 mg PO

Additional ☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

Additional Orders/Comments:

Hypersensitivity/Anaphylaxis Response Protocol PRN

PHYSICIAN INFORMATION

By signing this form and utilizing ur services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____