

Date: \_\_\_\_\_ Treatment Location: \_\_\_\_\_

**PROVIDERS: 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: \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_

**Signature:** \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Email: \_\_\_\_\_

## PREMEDS

No Premeds

**Center will use Hypersensitivity protocol established by Infusion for Health and P.I.**

## BENLYSTA DOSAGE

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, Infusion for Health is authorized to administer generic or biosimilar.*

**Lab Orders:**  List: \_\_\_\_\_

Prior to first appointment  Other Frequency: \_\_\_\_\_

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.