

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
Please fax a copy of front and back of the insurance card(s).	

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis:

Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: _____

SQ BENLYSTA

Prescription	Directions	Quantity	Refills
<input type="checkbox"/> Benlysta AUTO-INJ 200mg/ml	Inject 200mg subcutaneously once weekly	4 x 200mg	_____
<input type="checkbox"/> Benlysta PFS 200mg/ml	Inject 200mg subcutaneously once weekly	4 x 200mg	_____

IV BENLYSTA

Flushing Orders:
• Per HPS protocol
PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed
Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion

Pre-Medication Orders:
• No routine pre-medication necessary. Orders will be obtained if patient has reaction and requires pre-medications for subsequent doses.
 Other: _____

BENLYSTA (belimumab):
Frequency: 3 doses at weeks 0,2 and 4 followed by infusions every 4 weeks thereafter
OR
 Maintenance: every 4 weeks
Dose: RPh will round up to the nearest vial size (120mg, 400mg) or Give exact dose (do NOT round)
 10mg/kg IV over at least 1 hour
 Other _____ IV over 1 hour
• Dilute in 250ml 0.9% Sodium Chloride
Duration: Refills x 1 year OR _____ infusions
LABS: with each infusion OR every _____
 CBC with Diff AST Albumin Serum Creatinine Other: _____
NOTE:
• Orders are initiated unless crossed out by provider

Prescriber's Signature: _____	Substitution Permitted	Dispense as Written	Date: _____
<small>I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.</small>			

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