INTRAMED Plus infusion services

BENLYSTA®

INFUSION & MEDICAL CENTER

1. ______________________ ______________ ______________________
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnosis):

Primary Diagnosis: _____ Systemic lupus erythematosus (SLE) ICD-10 Code: M32.9
_____ Lupus Nephritis ICD-10 Code: M32.1
_____ Other: ______________________ ICD-10 Code: __________

Allergies: ____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including any recent antibody testing results (i.e. ANA)
- Medication List

Patient
Weight: __________ lbs.
Height: __________ in.

BENLYSTA® (Belimumab) J Code: J0490

4. Drug Order:

❑ **New Start:** ______# Refills (Recommend 8 Refills)
Administer 10 mg/kg (_______ mg) IV on Week 0, Week 2, Week 4 and then every 4 weeks thereafter

❑ **Maintenance Regimen:** ______# Refills (Recommend 6 Refills)
Administer 10 mg/kg (_______ mg) IV every 4 weeks

Pre-Medication Orders: ____
No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ______________________ / ______________________ Date: __________
Dispense as written Substitution permitted

Printed Physician's Name: ______________________ Contact Phone #: ______________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337

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