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**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

FEB 2021