



Benlysta® (belimumab) Order Form

Please include the following (required):

- 1. Patient Demographics & Insurance Information
- 2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

Patient Name

DOB

Weight

Allergies

Patient Phone

Medical History

Patient previously treated for Lupus? Yes No

If yes, include treatment history and dates _____

Diagnosis (Include ICD10 code)

Systemic Lupus Erythematosus _____ date diagnosed: _____

other: _____

Prescription Orders: Benlysta® (belimumab)

Initial dosing: Benlysta 10mg/kg IV every 2 weeks for first three doses then every 4 weeks

Renewal: Benlysta 10mg/kg IV every 4 weeks

(Infuse in Normal Saline 0.9% - 250 milliliters over 60 minutes)

Pre-Medications: Acetaminophen 650mg PO Benadryl 25 mg IVP

Solu-Medrol 40mg IVP Other _____

Lab Orders: _____

Refills: 12 months _____ infusions

Physician Name

Phone

Fax

Physician's signature

Date

Fax completed form to (214) 887-0436. Contact us directly at: (214) 276-5642.

Or visit us online at www.ntinfusioncenters.com