



MEDICATION ORDERS

BENLYSTA (BELIMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency	<input type="checkbox"/> Change Order Renewal

INFUSION OFFICE PREFERENCE (Optional)	
Preferred Location:	<input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Autoantibody-Positive, Systemic Lupus Erythematosus (SLE)	ICD 10 Code: M32.9
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Pregnancy Test (if applicable)	<input type="checkbox"/> ANA (anti-nuclear Ab) and/or anti-dsDNA Test Results

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS	
Initial dosing	<input type="checkbox"/> Benlysta 10 mg/kg IV at Week 0, 2, 4 then every 4 weeks thereafter <input type="checkbox"/> Benlysta _____ mg IV at Week 0, 2, 4 then every 4 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Benlysta 10mg/kg IV every 4 weeks <input type="checkbox"/> Benlysta _____ mg IV every 4 weeks
Refills:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses (all doses including initial loading)
<ul style="list-style-type: none">• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

PREMEDICATIONS	
<input checked="" type="checkbox"/>	Acetaminophen 1000mg PO, 30-60 minutes prior to Benlysta infusion
<input checked="" type="checkbox"/>	Diphenhydramine 25mg IV, 30 minutes prior to Benlysta infusion
<input checked="" type="checkbox"/>	Methylprednisolone 80mg IV 30 minutes prior to Benlysta infusion
<input type="checkbox"/>	Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207