

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

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

Diagnosis: Systemic Lupus Erythematosus (ICD 10: M32.9) Other

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 CoxHealth at Home 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: _____ Date: _____

I authorize CoxHealth at Home 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 CoxHealth at Home.

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