CoxHealth	at Home
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BENLYSTA[®]

CoxHealth	(belimumab)	Fax: 1-417-269-0692
Patient Information	Prescriber	
Name:DOB:	Prescriber name:	
Height: 🖬 in 🖬 cm Weight 🖬 kg 🕻	lbs NPI:	
Address:	Address:	
City: State: Zip:	City:	State: Zip:
Phone: Alternate:	Contact:	
SSN:	Phone:	Fax:
PLEASE INCLUDE ON FAX A COPY OF FRO AND BACK OF INSURANCE CARD(S)		
Clinical Information (Please fax all pertine Diagnosis: DM32.9 (Systemic Lupe		-
Other:		
Allergies:		
Intravenous BENLYSTA®		
Flushing/Premedication Orders:		
 Flushing per CoxHealth at Home protocol 		
 PIV: 0.9% sodium chloride 3-20mL before and 		
 Port: 0.9% sodium chloride 3-20mL into port a fore and after infusion as needed, Heparin 100 		
✓ No routine premedication necessary. If desired, please write here:		
BENLYSTA [®] (belimumab) IV over at least 1 hour		
Frequency:		
□ Loading Frequency: (3 doses at weeks 0,2 and 4 followed	d by infusions every 4 week	s thereafter)
OR		
Maintenance frequency: every 4 weeks		
Dose: Rph will round up to the nearest combination of via	ıl size (120mg, 400mg). Dilı	ute in 250mL0.9% sodium chloride
🗅 10mg/kg 🖵 Other		
Quantity to dispense: \Box 1 dose with 13 refills (1 year) or \Box]infusion(s)	
Labs: every (frequency) 🖵 CBC with diff 🗖	CMP 🖵 Other:	
Prescriber's Signature:		Date
I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insuranc stand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.	ce prior authorization process for this prescription	and any future fills of the same prescription for the patient listed above. I under-

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