Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Autoantibody-Positive, Systemic Lupus Erythematosus (SLE) ICD 10 Code: M32.9

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis
☐ ANA (anti-nuclear Ab) and/or anti-dsDNA Test Results

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS**

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

Initial Dosing	☐ J0490 Benlysta 10mg/kg IV at Week 0, 2, 4 then every 4 weeks thereafter**
	☐ J0490 Benlysta _____ mg IV at Week 0, 2, 4 then every 4 weeks thereafter
Maintenance Dosing	☐ J4090 Benlysta 10mg/kg IV every 4 weeks**
	☐ J0490 Benlysta _____ mg IV every 4 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses (all doses including initial loading)**

PREMEDICATIONS

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg IV Push or PO
☐ Methylprednisolone 100mg Slow IV Push
☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - BENLYSTA (BELIMUMAB)

Clinics Scan to: Physician Orders