INTRAMED Plus
infusion services

BENLYSTA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnosis):

Primary Diagnosis: _____ Systemic lupus erythematosus (SLE) ICD-10 Code: M32.9

_____ Lupus Nephritis ICD-10 Code: M32.1

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including any recent antibody testing results (i.e. ANA)
- Medication List

Patient
Weight: _____ lbs.
Height _____ in.

BENLYSTA® (Belimumab) J Code: J0490

4. Drug Order:

❑ **New Start:** _____# Refills (Recommend 8 Refills)

Administer 10 mg/kg (_____ mg) IV on Week 0, Week 2, Week 4 and then every 4 weeks thereafter

❑ **Maintenance Regimen:** _____# Refills (Recommend 6 Refills)

Administer 10 mg/kg (_____ mg) IV every 4 weeks

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**