

Benlysta (Belimumab) Referral order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

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☐ New Referral ☐ Restart ☐ Medication/ Order Change ☐ Verify Benefits Only ☐ D/C Infusions
(New Order Rqd.) *indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

Office Contact: _____

Phone # & Ext.: _____ Fax #: _____

Direct Message _____

Address _____

BENLYSTA MEDICATION ORDERS

Patient Weight: _____ kg ☐ Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 4 weeks then every _____ weeks.

☐ Maintenance Dosing: _____ mg/kg IV every _____ weeks.

Premeds: ☐ antihistamines _____ ☐ H2 antagonist _____ ☐ corticosteroids _____

INDICATION/DIAGNOSIS

- ☐ M32.9 Other forms of systemic lupus erythematosus
☐ M32.9 Systemic lupus erythematosus, unspecified
☐ Other (please specify in notes)

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Ordering Provider's Signature _____

Date _____

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY