

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Sex		Male	Female	Weight (kg)		Height (ft,in)		Nurse/Key Contact	Phone/Pager
Insurance Plan			Plan ID #			Fax		Email	

Diagnosis/Clinical Information				
ICD-10-CM: M32.10 Systemic lupus erythematosus		M32.9 Systemic lupus prythematosus, unspecified		Other:
Patient previously treated for lupus: No Yes				
Previous therapies: _____				
Current therapies: _____				
Medication list:				
Pre-medications (to be taken _____ minutes prior to infusion):				
Drug	Strength	Directions	QTY	Refill
Site of care for patient: Office Infusion center Home health agency				

Prescription Information				
MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Benlysta (Initial Dosing) (belimumab) Current weight: _____ kg	120mg (5mL vial)	Initial dosing: Infuse 10mg/kg IV over one hour every 2 weeks for first 3 doses  Total dose: _____mg	QS	0
	400mg (20mL vial)			
Benlysta (Maintenance Dosing) (belimumab) IV Administration Current weight: _____ kg	120mg (5mL vial)	Maintenance dosing: Infuse 10mg/kg IV over one hour every 4 weeks  Total dose: _____mg	QS	
	400mg (20mL vial)			
Benlysta (Maintenance Dosing) (belimumab) SC Administration Current weight: _____ kg	200mg/mL PFS	Inject 200mg SC once weekly	28 day supply	
	200mg/mL Autoinjector			

Date needed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medication delivery to (choose one): Prescriber Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: \_\_\_\_\_

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (Date) DISPENSE AS WRITTEN/Do Not Substitute (Date)

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