PARAGON INFUSION CENTERS

BENLYSTA (BELIMUMAB) INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

J Code: J0490 Diagnosis: ☐ Systemic Lupus Erythematosus ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of last ANA Test: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

BENLYSTA ORDERS

Benlysta

☐ Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter

☐ Maintenance: 10mg/kg IV every 28 days

Protocol:

☐ **Tylenol 1000mg PO, *please choose one antihistamine:***

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10mg PO

Additional:

☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta