

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Rev 2.24.25

Benlysta® (belimumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	See list
	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

M32.10 - Systemic lupus erythematosus, organ or system involvement
M32.14 - Glomerular disease in systemic lupus erythematosus
M32.15 - Tubulo-interstitial nephropathy in systemic lupus erythematosus
- Other:

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4 Tried and failed therapies	FROM PREVIOUS	
	THERAPY:	IF ORDER CHANGE:
		Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive belimumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

MEDICATION/DOSE:

Benlysta® (belimumab) 10mg/kg per 250ml IV NS to be infused over 1 hour.

FREQUENCY:

Induction orders to be completed at 0 week, 2 week, and 4 weeks

Maintenance orders every 4 weeks

Other: _____

SPECIAL/LAB ORDERS:

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
--	--

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted



Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com