NORTH TEXAS INFUSION CENTERS

Benlysta® (belimumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____
Weight **Allergies** **Patient Phone**

Medical History
Patient previously treated for Lupus? ☐ Yes ☐ No
If yes, include treatment history and dates_____

Diagnosis (Include ICD10 code)
☐ Systemic Lupus Erythematosus _____date diagnosed:_____
☐ other: _____

Prescription Orders: Benlysta® (belimumab)

☐ Initial dosing: Benlysta 10mg/kg IV every 2 weeks for first three doses then every 4 weeks
☐ Renewal: Benlysta _____ IV every 4 weeks
(Infuse in Normal Saline 0.9% - 250 milliliters over 60 minutes)

Pre-Medications: ☐ Acetaminophen 1000mg PO ☐ Benadryl 25 mg IVP
☐ Solu-Medrol 100mg IVP ☐ Other_____

Lab Orders:_____

Refills: ☐ 12 months or ☐_____infusions

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com