

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Autoantibody-Positive, Systemic Lupus Erythematosus (SLE)		ICD 10 Code: M32.9	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)	
<input type="checkbox"/> Patient demographics AND insurance information		<input type="checkbox"/> Labs and Tests supporting primary diagnosis	
*Patient may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> ANA (anti-nuclear Ab) and/or anti-dsDNA Test Results	
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
MEDICATION ORDERS**			
Dosing Wt for Calculations		Ht:	Wt (in kg):
		BMI:	**Patient weight required for weight-based orders.
Initial Dosing	<input type="checkbox"/> J0490 Benlysta 10mg/kg IV at Week 0, 2, 4 then every 4 weeks thereafter**		
	<input type="checkbox"/> J0490 Benlysta _____ mg IV at Week 0, 2, 4 then every 4 weeks thereafter		
Maintenance Dosing	<input type="checkbox"/> J4090 Benlysta 10mg/kg IV every 4 weeks**		
	<input type="checkbox"/> J0490 Benlysta _____ mg IV every 4 weeks		
Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses (all doses including initial loading)
PREMEDICATIONS			
<input type="checkbox"/> Acetaminophen 650mg PO			
<input type="checkbox"/> Diphenhydramine 25mg IV Push or PO			
<input type="checkbox"/> Methylprednisolone 100mg Slow IV Push			
<input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:		Office Fax:	Office Email:
Prescriber Signature:		Date:	Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
Ph. 217-258-4150
217-342-7500
Fax Completed Form and all documentation to: Fax 217-342-7499