

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

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		
DIAGNOSIS AND ICDE 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"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> ANA (anti-nuclear Ab) and/or anti-dsDNA test results	
List tried and failed therapies including duration of treatment:		
1) _____		
2) _____		
3) _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ Pt WT 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"/> J0490 Benlysta 10mg/kg IV every 4 weeks <input type="checkbox"/> J0490 Benlysta _____mg IV every 4 weeks	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS		
<input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Diphenhydramine 25mg IV push or PO <input type="checkbox"/> Methylprednisone 100 mg slow IV push <input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/ INFORMATION		
PRESCRIBER INFORMATION		
Provider 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 PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –BENLYSTA (BELIMUMAB)