Intravene - Benlysta Infusion Orders (rev 4/2022)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____Sex_____
Height _____ Weight _____
Allergies _____
Primary Insurance _____
Secondary Insurance _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone _____
Physician Fax _____
NPI# _____ DEA # _____
State License#_____

** ***Please fax copy of insurance cards*** **and this form to (434)- 455-5531***

DIAGNOSIS: (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

STANDARD ORDERS

Infuse Benlysta 10mg/kg in Normal Saline 250ml over 1 hour

- ☐ Initial order: Weeks 0, 2, and 4 then every 4 weeks for 1 year
- ☐ Renewal order: Every 4 weeks for 1 year

Infuse per Intravene protocol. Upon completion of Benlysta infusion, infuse Normal Saline 20ml.

Premedications:

- ☐ Premed: _____ Dose: _____mg _____min prior to infusion
- ☐ Premed: _____ Dose: _____mg _____min prior to infusion
- ☐ Premed: _____ Dose: _____mg _____min prior to infusion

Labs:

- ☐ None
- ☐ _____

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____