



LivWell
INFUSIONS

Benlysta Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: M32.9: Systemic Lupus Erythematosus
Other: _____
ICD-10 _____

Patients weight: _____
Lab Date: _____
Allergies: _____

ALSO INCLUDE...

Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

BENLYSTA ORDER

Benlysta Dose: Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 4 weeks then every _____ weeks.

Maintenance Dosing: _____ mg/kg IV every _____ weeks.

Patients weight (kg): _____

Premeds: antihistamines: _____ H2 antagonist: _____ corticosteroids: _____

Date of last Benlysta Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____