



Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

Benlysta Order Form

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- ☐ Systemic Lupus Erythematosus ICD-10 Code: _____
☐ Lupus Nephritis ICD-10 Code: _____
☐ Other Diagnosis: _____ ICD-10 Code: _____

ORDER FOR BENLYSTA (BELIMUMAB):

- ☐ Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter x1 year
☐ Maintenance Dose: 10mg/kg IV every 28 days x1 year
☐ Other Dosing: _____ x 1 year

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS Pre/Post Infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****



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Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)?
 - ☐ Yes OR ☐ No
 - If yes, which drug(s)? _____

- ☐ Does the patient have a history of a positive autoantibody test?
 - ☐ Yes OR ☐ No
 - If yes, which test(s)? _____

- ☐ SELENA-SLEDAI score: _____

- ☐ Indicate any symptoms the patient has:
 - ☐ Malar rash
 - ☐ Discoid rash
 - ☐ Photosensitivity
 - ☐ Oral ulcers
 - ☐ Nonerosive arthritis
 - ☐ Pleuritis/pericarditis
 - ☐ Renal disorder
 - ☐ Hematologic disorder

- ☐ Include labs and/or test results to support diagnosis
 - ☐ ANA, Anti-dsDNA, Anti-Ro/SSA
 - ☐ Other medical necessity documentation to support therapy: _____

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