



NEVADA
INFUSION

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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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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