BENLYSTA (BELIMUMAB) Referral Order Form

FAX (855) 891-2191

Effective: 07/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191 Email: mppreferral@mppinfusion.com

___ Denver ___ Arlington ___ Dallas ___ Duncanville ___ Irving ___ Lewisville ___ Plano ___ Southlake

___ New Referral ___ Restart ___ Medication/ Order Change *(New Order Required)* ___ Benefits Verification Only ___ D/C Infusions **indicate name of drug(s)* ________________

PATIENT INFORMATION

Name: ________________________ Date: _________

DOB: ________________ SS# _________________

Phone # ___________________

Email: ____

PHYSICIAN INFORMATION

Referring Physician: _________________________________

Practice Name: ____________________________________

Specialty: ____

Office Contact: _____________________________________

Contact Phone # __________ Contact Fax # ___________

Contact Email: _____________________________________

BENLYSTA MEDICATION ORDERS

Patient Weight: _____kg

_ Initial/Reload Dosing: __________ mg/kg IV on day 0, 2 weeks, 4 weeks then every ____ weeks.

_ Maintenance Dosing: __________ mg/kg IV every ____ weeks.

INDICATION/DIAGNOSIS

_ Antibody- positive, systemic lupus erythematosus

_ Other *(please specify in notes)*

***ICD-10** ___________________________ **required**

NOTES (ADDITIONAL INFO)

________________________________ __________

Referring Physician's Signature Date *valid for one year

STANDING LAB ORDERS

Labs to be drawn by:

_ Referring Physician

_ Infusion Center

Orders:

_ CMP _ CBC _ CRP

_ ESRP _ HFP _ UA

Frequency:

_ Every Infusion

_ Other ________________

REQUIRED DOCUMENTATION

_ Recent Office notes (along with any therapies tried and outcomes) _ Current Medication List _ History and Physical Report

_ Lab Results _ Insurance Cards (front and back) _ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

_ ANA (SLE)

APPOINTMENT DATE & TIME: ______________________________________

FOR OFFICE USE ONLY