

Benlysta (belimumab)

Provider Order Form rev. 12/30/2025



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Primary diagnosis)

- M32.1 Systemic lupus erythematosus, organ or system involvement unspecified Other: _____
- M32.11 Endocarditis in systemic lupus erythematosus
- M32.12 Pericarditis in systemic lupus erythematosus
- M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- Acetaminophen (Tylenol) 500mg 650mg 1000mgPO
 Cetirizine (Zyrtec) 10mgPO
 Loratadine (Claritin) 10mgPO
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) 40mg 125mg IV
 Hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____ Dose: _____ Route: _____ Frequency: _____

Lab Orders

Required: Positive autoantibody results: i.e. Anti-dsDNA, Antinuclear Antibody (ANA), Anti-Smith
 Other: _____

Benlysta (belimumab) IV (Select one):

Loading Dose:

- Dose: 10 mg/kg in 250 mL of 0.9% Sodium Chloride over at least 60 minutes at weeks 0, 2, and 4
 Other: _____

Maintenance Dose:

- Dose: 10 mg/kg in 250 mL of 0.9% Sodium Chloride over at least 60 minutes every 4 weeks for one year
 Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

Refills: zero for 12 months _____
(If not indicated the medication order will expire one year from date signed)

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454