Benlysta®

Referring Physician Orders Rev. 4/2026

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ M32.10 Systemic lupus erythematosus, organ or system involvement

☐ M32.14 Glomerular disease in systemic lupus erythematosus

☐ M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus

☐ Other: ______________________, ICD-10 ________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Benlysta® (belimumab)	☐ _____ mg (10mg/kg)	☐ Initial: Infuse IV over 1 hour at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ Maintenance: Infuse IV over 1 hour every 4 weeks x 1 year

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q ________ ☐ CMP q ________ ☐ CRP q ________ ☐ ESR q ________ ☐ LFTs q ________ ☐ Other: ________________

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: ________________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician

Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizimab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: ☐ Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________