



Please Fax Completed Form To: 888-340-3699

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Needs

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

M32.0 Drug-induced Systemic Lupus Erythematosus M32.1 Systemic Lupus Erythematosus (organ or system involvement) L93.0 Discoid Lupus Erythematosus

M32.9 Systemic Lupus Erythematosus, unspecified Other: _____

Has patient been previously treated for this condition? Yes No Is patient currently on therapy? Yes No

BENLYSTA® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Benlysta® (belimumab)	<input type="checkbox"/> 10mg/KG at 0, 2 and 4 weeks; then every 4 weeks <input type="checkbox"/> _____ mg IV at 0, 2 and 4 weeks; then every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity: _____ <input type="checkbox"/> Refills: _____

INFUSION REACTION ORDERS

Mild reaction protocol:

Diphenhydramine 25mg IV, one time, for pruritus.
If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

Acetaminophen 650mg PO, one time, for pyrexia or rigors
 Diphenhydramine 50mg IV, one time, for pruritus or urticaria
 Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms
If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
 Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
 Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
 Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
 Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

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FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)	
PIV and Midline: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)		
PIV and Midline: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	PICC: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	Implanted Port, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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