



BENLYSTA® (belimumab) Referral Form

RETURN COMPLETED FORM VIA FAX TO:

888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Alt. Phone: _____
 DOB: _____ Gender: M F Last 4 SSN: _____
 WT: _____ HT: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 State License: _____ NPI #: _____
 DEA: _____ Phone: _____
 Address: _____ Fax: _____
 City, State, Zip: _____
 Contact Person: _____ Phone: _____

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: _____ RX Card (PBM): _____
 City, State, Zip: _____ BIN: _____ PCN: _____
 Plan #: _____ City, State, Zip: _____
 Group #: _____ Group #: _____
 Phone: _____ Phone: _____

DIAGNOSIS/CLINICAL INFORMATION

<input type="checkbox"/> M32.0 – Drug-induced Systemic Lupus Erythematosus	<input type="checkbox"/> M32.9 – Systemic Lupus Erythematosus, unspecified
<input type="checkbox"/> M32.1 - Systemic Lupus Erythematosus with organ or system involvement	<input type="checkbox"/> L93.0 - Lupus Erythematosus (discoid) (NOS)
<input type="checkbox"/> M32.8 – Other forms of Systemic Lupus Erythematosus	
<input type="checkbox"/> Other Code: _____	Description: _____

Needed by Date: _____ Ship to: Patient Office Other:

Lab Orders: _____

BENLYSTA DOSING

- Benlysta 10mg/KG at 0, 2 and 4 weeks; then Q 4 week: Refills for 1 year
- Benlysta _____ mg IV at 0, 2 and 4 weeks; then Q 4 week: Refills for 1 year
- Specific dose of: _____

SIGNATURE

X _____ DATE: _____
 Prescribing Physician 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.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Thank you for choosing Talis Healthcare

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