TALIS HEALTHCARE

BENLYSTA® (belimumab) Referral Form

RETURN COMPLETED FORM VIA FAX TO:
888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____ Phone: _____
Phone: _____ Alt.Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: M F Last 4 SSN: _____	City, State, Zip: _____
WT: HT: Allergies:	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

☐ M32.0 – Drug-induced Systemic Lupus Erythematosus	☐ M32.9 – Systemic Lupus Erythematosus, unspecified
☐ M32.1 - Systemic Lupus Erythematosus with organ or system involvement	☐ L93.0 - Lupus Erythematosus (discoid) (NOS)
☐ M32.8 – Other forms of Systemic Lupus Erythematosus	
☐ 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.

Thank you for choosing Talis Healthcare

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