BENLYSTA®

Please Fax Completed Form To: 888-898-9113

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ Alt. Phone: ______________

Email: ______________ SS#: ______________

Gender: ☐ M ☐ F Weight: ________(lbs) Ht: __________

Allergies: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________

State License: ______________________

NPI #: ______________ Tax ID: ______________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ Fax: ______________

Office Contact: ______________ Phone: __________

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

Primary Insurance: ______________________

Plan #: ______________________

Group #: ______________________

RX Card (PBM): ______________________

BIN: ______________ PCN: ______________

Secondary Insurance (If Applicable): ______________________

Plan #: ______________________

Group #: ______________________

RX Card (PBM): ______________________

BIN: ______________ PCN: ______________

CLINICAL INFORMATION

☐ M32.0 Drug-induced Systemic Lupus Erythematosus

☐ L93.0 - Lupus Erythematosus (discoid) (NOS)

☐ M32.1 Systemic Lupus Erythematosus (organ or system involvement)

☐ Other: ______________________

☐ M32.9 Systemic Lupus Erythematosus, unspecified

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
☐ Benlysta® (belimumab)	☐ 10mg/KG at 0, 2 and 4 weeks; then every 4 weeks ☐ __________mg IV at 0, 2 and 4 weeks; then every 4 weeks ☐ Other: ______________________	☐ Quantity: __________ ☐ Refills: __________

SIGNATURE

We hereby authorize Talis Healthcare 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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