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.

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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