PURE INFUSION SUITES

Fax form to:
Billings - 406.206.0105
Great Falls - 406.794.0555
Boise - 208.545.3214
Colorado Springs - 719.623.0085
Grand Junction - 970.404.8100

INFUSION ORDERS BENLYSTA (belimumab)

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax most recent labs and any labs pertinent for this drug.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

BENLYSTA DOSING

☐ Benlysta 10mg/kg at 0, 2, and 4 weeks; then Q 4 weeks

Refills:

☐ Benlysta 10mg/kg Q 4 week

Refills:

***Infusion Nurse – Use Benlysta Vial Calculator**

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date

Provider Phone | Provider Fax