



LUPUS REFERRAL FORM

Phone: 855.896.9254 Fax: 877.645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Sex	Male	Female	Weight (kg)		Height (ft,in)	Nurse/Key Contact		Phone/Pager	
Insurance Plan			Plan ID #			Fax		Email	

Diagnosis/Clinical Information

ICD-10-CM: M32.10 Systemic lupus erythematosus M32.9 Systemic lupus erythematosus, unspecified Other:

Patient previously treated for lupus: No Yes

Previous therapies: _____

Current therapies: _____

Medication list:

Pre-medications (to be taken _____ minutes prior to infusion):

Drug	Strength	Directions	QTY	Refill

Site of care for patient: Office Infusion center Home health agency

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Benlysta (Initial Dosing) (belimumab) Current weight: _____kg	120mg (5mL vial)	Initial dosing: Infuse 10mg/kg IV over one hour every 2 weeks for first 3 doses Total dose: _____mg	QS	0
	400mg (20mL vial)			
Benlysta (Maintenance Dosing) (belimumab) IV Administration Current weight: _____kg	120mg (5mL vial)	Maintenance dosing: Infuse 10mg/kg IV over one hour every 4 weeks Total dose: _____mg	QS	
	400mg (20mL vial)			
Benlysta (Maintenance Dosing) (belimumab) SC Administration Current weight: _____kg	200mg/mL PFS	Inject 200mg SC once weekly	28 day supply	
	200mg/mL Autoinjector			

Date needed: ____/____/____ Medication delivery to (choose one): Prescriber Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (Date) DISPENSE AS WRITTEN/Do Not Substitute (Date)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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