PARAGON HEALTHCARE

A Carelon Company

BENLYSTA (BELIMUMAB) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Systemic Lupus Erythematosus

☐ Lupus Nephritis ☐ Other: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Benlysta: ☐ Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter x1 year

☐ Maintenance: 10mg/kg IV every 28 days x1 year

Pre-Medication Orders: ☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

☐ Other: _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

A Carelon Company

COMPREHENSIVE SUPPORT FOR BENLYSTA (BELIMUMAB) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)? ☐ Yes ☐ No If yes, which drug(s)? _____
  - ☐ Does the patient have a history of a positive autoantibody test? ☐ Yes ☐ No If yes, which test(s)? _____
  - ☐ SELENA-SLEDAI score: _____
  - ☐ Indicate any symptoms the patient has:
    ☐ Malar rash ☐ Discoid rash ☐ Photosensitivity ☐ Oral ulcers ☐ Nonerosive arthritis
    ☐ Pleuritis/pericarditis ☐ Renal disorder ☐ Hematologic disorder
- ☐ Include labs and/or test results to support diagnosis
  - ☐ ANA, Anti-dsDNA, Anti-Ro/SSA
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance