BENLYSTA® Infusion

OptiMed
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Phone: 877.385.0535
Fax: 877.326.2856

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose? ☐Yes ☐No (Date of last dose: _____ Prior dose: _____) **Prior infusion reactions:** _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care
*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

BENLYSTA® Dose	Dosing Regimen	Number of Doses
☐10mg/kg	☐**Induction Dosing:** Infuse IV* at week 0, 2, and 4, then begin maintenance dosing every four weeks.	3 doses (infusions)
☐Other:	☐**Maintenance Dosing:** Beginning week 8, infuse IV* every 4 weeks.	_____ doses (infusions)
_____	☐**Alternative Dosing:** _____	_____ doses (infusions)
	*Pharmacy and nursing to determine compatible diluent and appropriate rate per protocol, prescribing information, and evidence-based practices.	

Premedication(s): ☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion
☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion
☐Other premedication(s): _____

PRN Medication(s): ☐Acetaminophen 325-650mg PO Q4 hours PRN ☐Diphenhydramine 50mg IV x1 dose PRN
☐Methylprednisolone 125mg IV x1 dose PRN ☐Other PRN medication(s): _____

Laboratory orders (subject to availability): _____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM