Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Lupus – Benlysta®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

Diagnosis Code ☐ M32.9 Active Systemic Lupus Erythematosus

☐ M32.14 Glomerular disease in systemic lupus erythematosus ☐ Other _____

Height _____ cm Weight _____ kg Date Measured / /

Date of Negative TB Test / /

Prior Treatment? ☐ Y ☐ N (Provide Information Below) Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /

Approx. End Date / /

Comorbidities _____

Concomitant Medications _____

Allergies ☐ NKDA ☐ Other _____

Community Memorial HEALTHCARE

Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **BENLYSTA®** *SLE - Pediatrics (age 5+)	☐ 1 carton (4x200 mg/ml) PEN ONLY	☐ Weight 15-39 kg: Inject 200 mg SQ every 2 weeks ☐ Weight 40 kg+: Inject 200 mg SQ once every week.	
☐ **BENLYSTA®** *SLE ☐ PFS ☐ Pen	☐ 1 carton (4x200 mg/ml)	☐ Inject 200 mg SQ once every week	
☐ **BENLYSTA®** *Lupus nephritis ☐ PFS ☐ Pen	☐ 2 cartons (8x200 mg/ml)	☐ Starter Dose: Inject 400 mg (two 200 mg injections) SQ once weekly for 4 doses	No Refills
	☐ 1 carton (4x200 mg/ml)	☐ Maintenance Dose: Inject 200 mg SQ once every week	
☐ Other			

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*

Date _____

Prescriber Signature _____ *Dispense as Written*

Date _____

If brand is required, please write "DAW" in the box to the right. ☐