

**TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

**BENLYSTA ORDER FORM**

Date: _____	ICD-10 Code: _____	<b>Therapy Status</b> <input type="checkbox"/> New Start  <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

**Provider Information**

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

**MEDICATION ORDER****Benlysta**

- Administer Benlysta 10mg/kg IV every 2 weeks for a total of three doses, followed by Benlysta 10mg/kg IV every four weeks per protocol.
- Administer Benlysta 10mg/kg IV every four weeks per protocol.
- Administer Benlysta \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks per protocol.

Refills for one year from date of signature unless indicated below.

\_\_\_\_\_ Refills

**PRE-MEDICATIONS****Oral**

- Acetaminophen: \_\_\_\_\_ 325mg \_\_\_\_\_ 500mg \_\_\_\_\_ 650mg
- Loratadine: 10mg
- Cetirizine: 10mg
- Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg
- Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg
- Ibuprofen: \_\_\_\_\_ 200mg \_\_\_\_\_ 400mg \_\_\_\_\_ 600mg
- Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Other: \_\_\_\_\_

**IV**

- Dexamethasone: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg
- Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg
- Methylprednisolone: 125mg
- Hydrocortisone: 100mg
- Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Other: \_\_\_\_\_

**LAB ORDERS** (please indicate any labs to be drawn and frequency)**OTHER REQUIRED DOCUMENTATION**

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

Substitution Allowed:

Prescriber Name \_\_\_\_\_

Date \_\_\_\_\_

Prescriber Name \_\_\_\_\_

Date \_\_\_\_\_