Rx meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

# 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

| | | | | | | |
|---|---|---|---|---|---|---|
| Patients Name: | Last 4 Digits of SS#: | DOB: / / | Sex: M F | Weight: | Height: | Diabetic? Y N |
| Office Contact: | | | Practice Name / Collaborating MD: | | | |
| Address: | | City: | | State: | Zip: | |
| Home Phone: | Work/Cell: | | HIPPA 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: / /<br>Approx. End Date: / / | | |
| Comorbidities: | Concomitant Medications: | Allergies: NKDA Other: | | |

## Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|---|---|---|
| **BENLYSTA®**<br>**SLE*<br>PFS Pen | 1 carton (4x200mg/ml) | **Maintenance Dose:** Administer 200mg SQ once every week | |
| **BENLYSTA®**<br>**Lupus nephritis*<br>PFS Pen | 2 cartons (8x200mg/ml) | **Starter Dose:** Inject 400mg (two 200mg injections) SQ once weekly for 4 doses | **No Refills** |
| | 1 carton (4x200mg/ml) | **Maintenance Dose:** Inject 200mg SQ once every week | |
| **Other:** | | | |

## Injection Training

| | | |
|---|---|---|
| Patient received injection training | Prescriber's office to provide injection training | Meijer to coordinate injection training |

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

| | | | |
|---|---|---|---|
| Prescriber Signature | Date | Prescriber Signature | Date |
| Substitution Permitted | | Dispense as Written | |

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