meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

○ 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

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:	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:	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
○ **BENLYSTA®** **SLE* ○ **PFS** ○ **Pen**	○ 1 carton (4x200mg/ml)	○ **Maintenance Dose:** Administer 200mg SQ once every week	
○ **BENLYSTA®** **Lupus nephritis* ○ **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.