

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
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
<b>BENLYSTA®</b> *SLE - Pediatrics (age 5+)	1 carton (4x200mg/ml) PEN ONLY	<u>Weight 15-39kg:</u> Inject 200mg SQ every 2 weeks <u>Weight 40kg+:</u> Inject 200mg SQ once every week	
<b>BENLYSTA®</b> *SLE PFS Pen	1 carton (4x200mg/ml)	Inject 200mg SQ once every week	
<b>BENLYSTA®</b> *Lupus nephritis PFS Pen	2 cartons (8x200mg/ml)	<b>Starter Dose:</b> Inject 400mg (two 200mg injections) SQ once weekly for 4 doses	<b>No Refills</b>
	1 carton (4x200mg/ml)	<b>Maintenance Dose:</b> Inject 200mg SQ once every week	
<b>Other:</b>			

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
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Substitution Permitted

Dispense as Written

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