Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Benlysta (belimumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name ______ Last name ______ Middle initial ______

Sex at birth: Male Female Preferred pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ E-mail address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ E-mail address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ E-mail address ______

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact e-mail ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ E-mail ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ______ Has the patient been treated previously for this condition? Yes No

Is patient currently on therapy? Yes No Please list all therapies tried/failed: ______

Patient wt ______ Date obtained ______

NKDA Known drug allergies ______

Concurrent meds ______

Patient's first name ______ Last name ______ Middle initial ______ Date of birth ______

Prescriber's first name ______ Last name ______ Phone ______

4 Prescribing Information

Medication	Directions	Quantity/Refills	
Benlysta (belimumab)	**Intravenous:** Systemic lupus erythematosus and Lupus Nephritis **Loading dose:** 10mg/kg IV at 2 week intervals for the first 3 doses **Maintenance dose:** 10mg/kg IV every 4 weeks Other ______	**Intravenous:** **Loading dose:** 3 doses No refills	**Maintenance dose:** 1-month supply 3-month supply Refill x 1 year unless noted otherwise. Other ______
	Subcutaneous: Systemic lupus erythematosus 200mg subcutaneously once weekly	1-month supply 3-month supply Refill x 1 year unless noted otherwise. Other ______	
	Lupus Nephritis **Loading dose:** 400mg subcutaneously once weekly for 4 doses **Maintenance dose:** 200mg once weekly.	**Loading dose:** 1-month supply No refills	**Maintenance dose:** 1-month supply 3-month supply Refill x 1 year unless noted otherwise. Other ______

Required medication and supplies for home infusion (please complete this section for home infusions only)

Send quantity and refills sufficient for medication days supply.

Premedication orders

Acetaminophen 650mg PO 30 min prior to infusion; Diphenhydramine 50mg PO 30 min prior to infusion

Other ______

Infusion method: Gravity (Pediatric patients will be given a pump unless noted otherwise)

Fluids for administration and reconstitution (please strike through if not required)

NS 0.9% 250mL If preferred NS 0.9% 100mL ONLY for patients less than or equal to 40kg (final concentration of the 100mL bag should not exceed 4mg/mL). (if none selected NS 0.9% 250mL will be dispensed)

Sterile Water as needed for reconstitution

NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: Peripheral access Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis

Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

Start NS 0.9% 100mL at TKO Diphenhydramine 50mg slow IVP PRN anaphylaxis Hydrocortisone 100mg slow IVP PRN anaphylaxis

Methylprednisolone 125mg slow IVP PRN anaphylaxis Diphenhydramine 50mg PO PRN anaphylaxis

Other ______

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.
*If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Lab orders ______

Frequency ______

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

______ **Date** ______ **Dispense as written** ______ **Date** ______ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2022 Accredo Health Group, Inc. I An Express Scripts Company. All rights reserved. RAS-00047-H-110222 CRP2207_0016267.1