Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Benlysta (belimumab)

EVERNORTH HEALTH SERVICES

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

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

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 email _____

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 _____ Email _____

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	Strength/Formulation	Directions	Quantity/Refills
☐ Benlysta (belimumab)	☐ Benlysta 120mg single-dose vial (SDV) ☐ Benlysta 400mg SDV	**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 _____	**Loading dose:** ☐ 3 doses No refills **Maintenance dose:** ☐ 28-day supply ☐ 84-day supply Refill x 1 year unless noted otherwise ☐ Other _____
	☐ Benlysta 200mg/mL prefilled syringe (PFS) ☐ Benlysta 200mg/mL pen	**Subcutaneous:** Systemic Lupus Erythematosus ☐ 200mg subcutaneously once weekly	☐ 28-day supply ☐ 84-day 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:** ☐ 28-day supply No refills **Maintenance dose:** ☐ 28-day supply ☐ 84-day supply Refill x 1 year unless noted otherwise ☐ Other _____
☐ Other			

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

Send quantity and refills sufficient for medication dose and days supply.

Premedication orders

☐ Acetaminophen 650mg PO 30 min prior to infusion

☐ Diphenhydramine 50mg PO 30 min prior to infusion

☐ Other _____

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

☐ Prefer pump

☐ Other _____

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

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.

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information (cont.)

Required medication and supplies for home infusion (please complete this section for home infusions only)	
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 _____	Send quantity and refills sufficient for medication dose and days supply.
☐ 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.	

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.

EVERNORTH HEALTH SERVICES

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