Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

BENLYSTA ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

☐ Benlysta	☐ Administer Benlysta 10mg/kg IV every 2 weeks for a total of three doses, followed by Benlysta 10mg/kg IV every four weeks per protocol. ☐ Administer Benlysta 10mg/kg IV every four weeks per protocol. Administer Benlsysta _____mg/kg every _____ weeks per protocol.	***Refills x one year from date of signature unless indicated below.*** ☐ _____ Refills

PRE-MEDICATIONS

****Consider administering premedication for prophylaxis against infusion and hypersensitivity reactions****

Oral	IV
☐ Acetaminophen: ___325mg ___500mg ___650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ Other_____	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
****Surveillance lab ordering, and monitoring is the responsibility of the prescriber****	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ _____ Prescriber Name Date	_____ _____ Prescriber Name Date