Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Benlysta (Tocilizumab)
SubQ Injection Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, lab & imaging results
- ☐ Last ANA

Primary Diagnosis:

- ☐ Systemic Lupus Erythematosus (ICD-10:_____)
- ☐ Other:_____(ICD-10:_____)

BENLYSTA ORDERS

- ☐ Benlysta 400mg once weekly x 4 weeks, then 200mg once weekly thereafter
- ☐ Benlysta 200mg once weekly

Administered per manufacturer guidelines

PRE-MEDICATIONS

- ☐ PO Tylenol _____mg
- ☐ PO Cetirizine _____mg
- ☐ IV Solu-medrol _____mg
- ☐ PO Loratadine _____mg
- ☐ PO ☐ IV Diphenhydramine _____mg
- ☐ PO ☐ IV Other:_____ _____mg

LABS

- ☐ CBC
- ☐ CMP
- ☐ CRP
- ☐ ESR
- ☐ TB Quantiferon Gold
- ☐ Hep B Core/Surface AG
- ☐ Uric Acid
- ☐ Other:_____
- ☐ Other:_____

Frequency:

- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**