meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

Lupus
Benlysta®

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice name/Collaborating Physician:	
Address:		City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯M ◯F	Weight:	Height:	Diabetic: ◯Y ◯N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N		

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Diagnosis: ◯M32.9 Active Systemic Lupus Erythematosus ◯ Other

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯Yes ◯No (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities:	Concomitant Medications:
Allergies: ◯NKDA ◯Other:	
Start Date: / /	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **BENLYSTA®** **SLE* ◯ PFS ◯ Pen	◯ 1 carton (4x200mg/ml autoinjector) ◯ 1 carton (4x200mg/ml PFS)	◯ **Maintenance Dose:** Administer 200mg SQ once every week	
◯ **BENLYSTA®** **Lupus nephritis* ◯ PFS ◯ Pen	◯ 1 carton (4x200mg/ml autoinjector) ◯ 1 carton (4x200mg/ml PFS)	◯ **Starter Dose:** Inject 400mg (two 200mg injections) SQ once weekly for 4 doses	**No Refills**
	◯ 1 carton (4x200mg/ml) autoinjector ◯ 1 carton (4x200mg/ml) PFS	◯ **Maintenance Dose:** Inject 200mg SQ once every week	
OTHER:			

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

Substitution Permitted

Prescriber Signature:	Date

Dispense as Written

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