**Edward-Elmhurst Cancer Centers**
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

# Benlysta Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

## *PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER*

**Pre-Authorization # or Call Reference #:** _____
**(Ordering Physician Office is Responsible to Obtain Authorization/Referral)**

**Contact Name and Phone Number of Insurance Company:** _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD-10 Required): _____

Patient Weight (lbs/kg): _____

**Dosing Guidelines:** 10mg/kg given every 2 weeks times 3 doses and then every 4 weeks thereafter (dose may be rounded to nearest vial size)

**Dose:** _____ mg/250ml 0.9% IVPB over 1 hour.

**Pre-Medications:** (Please mark all that apply)

- ☐ Tylenol 650mg po prior to infusion
- ☐ Benadryl 25mg po prior to infusion
- ☐ Benadryl 25mg IVPB prior to infusion
- ☐ Other: _____

**In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.**

**In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.**

**Physician Signature:** _____ **Date:** _____

**Ordering Physician NPI:** _____ **Edward Hospital NPI:** **1427069632**
**Elmhurst Hospital NPI:** **1548306343**

| **Physician Name (Please Print)** | **Office Phone** | **Fax Number** |
|---|---|---|

Revision/Review Date: 07/01/2021