



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: _____ **Swedish Hospital NPI:** 1831151257

Physician Name (Please Print)

Revision/Review Date: 12/24

Office Phone

Fax Number