



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION		
<input type="checkbox"/> M32.0 Drug-induced Systemic Lupus Erythematosus	<input type="checkbox"/> M32.1 Systemic Lupus Erythematosus (organ or system involvement)	<input type="checkbox"/> M32.9 Systemic Lupus Erythematosus, unspecified
<input type="checkbox"/> L93.0 - Lupus Erythematosus (discoid) (NOS)	<input type="checkbox"/> Other: _____	
Has patient been previously treated for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

BENLYSTA® ORDERS	
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy	Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Benlysta® (belimumab)	<input type="checkbox"/> 10mg/KG at 0, 2 and 4 weeks; then every 4 weeks <input type="checkbox"/> _____ mg IV at 0, 2 and 4 weeks; then every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity: _____ <input type="checkbox"/> Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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