MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

BENLYSTA® (BELIMUMAB) REFERRAL

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

☐ **New Referral** ☐ **Referral Renewal** ☐ **Medication/Order Change**
☐ **Benefits Verification Only** ☐ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

BENLYSTA Infusion*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

☐ **Initial/Reloading Dosing and then Maintenance Dosing**:
10mg/kg IV on day 0, 2, 4 weeks and then every 4 weeks

OR

☐ **Maintenance Dosing Only**: 10mg/kg IV every 4 weeks

Physician Signature _____
***NPI#** _____

Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

☐ Antibody- positive, systemic lupus erythematosus

☐ Other_____

***STAT REASON:**
(Requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date _____

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Clinical/Progress Notes supporting DX
☐ Current Medication List and H&P
☐ ANA (SLE)

STANDING LAB ORDERS (to be drawn by clinic: ☐ CMP ☐ CBC *Frequency_____

FOR MPP USE ONLY

Referral Reviewed and Accepted by: _____ *Date approved:*_____
Additional information needed/ notes:

Locations:

--------Colorado--------
☐ Lakewood

---------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

------Oklahoma--------
☐ Tulsa

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 01/2022