



WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

- New Referral
- Restart
- Medication/ Order Change
(New Order Required)
- Benefits Verification
Only
- D/C Infusions
**indicate name of drug(s)*

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION **PHYSICIAN INFORMATION**

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

Referring Physician: _____

Practice Address: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____

BENLYSTA MEDICATION ORDERS

Patient Weight: _____ kg

Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 4 weeks then every _____ weeks.

Maintenance Dosing: _____ mg/kg IV every _____ weeks.

Premeds: antihistamines _____ H2 antagonist _____ corticosteroids _____

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

- M32.9 Other forms of systemic lupus erythematosus
- M32.9 Systemic lupus erythematosus, unspecified
- Other *(please specify in notes)*

***ICD-10** _____ **required**

Referring Physician's Signature

Date

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Current Medication List
- History and Physical Report
- Lab Results
- Insurance Cards (front and back)
- Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY