BLUEGRASS PHARMACY | LUPUS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ M32.10 Systemic lupus erythematosus

◯ Other:

Pre-medications
(to be taken _____ minutes prior to infusion)

Drug	Strength	Description

Allergies:

Current Medications:

Is patient taking medication from any of the following groups?
◯ Corticosteroids ◯ Antimalarials ◯ NSAIDs ◯ Immunosuppressives

Does patient have a latex allergy? ◯ Yes ◯ No

Height (in/cm): Weight (lb/kg):

Please select site of care for patient: ◯ Office ◯ Infusion Center ◯ Home Health Agency
Agency of choice:

Specialty pharmacy to coordinate home health nursing visit as necessary: ◯ Yes ◯ No

◯ Home health nursing visit coordination is not necessary
If no, reason: ◯ MD office to administer to patient
◯ Home health nursing already coordinated

Please select site of care for patient: ◯ Office ◯ Infusion Center ◯ Home Health Agency

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Benlysta	◯ 120 mg 5 ml vial ◯ 400 mg 20 ml vial	Dose: _____ mg/kg Total Dose: _____ mg ◯ Infuse IV over 1 hour every 2 weeks x 3 doses then every 4 weeks thereafter. ◯ Other:		◯ 1 year

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE