

FAX FORM TO: 1.866.233.8317

PHONE: 1.855.492.0817

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Complete the following or include demographic sheet.

1. PATIENT INFORMATION		2. PRESCRIBER INFORMATION	
Name: _____		Name: _____	
Address: _____		DEA #: _____	NPI #: _____ State Lic. #: _____
City, State, ZIP: _____		Group or Hospital: _____	
Primary Phone: - -	DOB: / /	Address: _____	
Alternate Phone: - -	Gender: _____	City, State, Zip: _____	
Email: _____		Phone: - -	Fax: - -
Primary Language: _____	Last Four of SSN: _____	Contact Person: _____ Phone: - -	

3. INSURANCE INFORMATION				<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>			
Primary Insurance Company Name: _____				Secondary Insurance Company Name: _____			
Primary Cardholder Name: _____				Secondary Cardholder Name: _____			
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent				Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent			
Phone: - -		Member ID: _____		Phone: - -		Member ID: _____	
		Group #: _____				Group #: _____	

4. DIAGNOSIS AND CLINICAL INFORMATION		
Needs by Date: / /		Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /		Is patient taking medication from any of the following groups? <input type="radio"/> Corticosteroids <input type="radio"/> Antimalarials <input type="radio"/> NSAIDs <input type="radio"/> Immunosuppressives
<input type="radio"/> M32.10 Systemic lupus erythematosus		Does patient have a latex allergy? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Other: _____		Height (in/cm): _____ Weight (lb/kg): _____
Pre-medications (to be taken _____ minutes prior to infusion)		Please select site of care for patient: <input type="radio"/> Office <input type="radio"/> Infusion Center <input type="radio"/> Home Health Agency
Drug	Strength	Description
Allergies: _____		Agency of choice: _____
Current Medications: _____		Specialty pharmacy to coordinate home health nursing visit as necessary: <input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Home health nursing visit coordination is not necessary
		If no, reason: <input type="radio"/> MD office to administer to patient
		<input type="radio"/> Home health nursing already coordinated
		Please select site of care for patient: <input type="radio"/> Office <input type="radio"/> Infusion Center <input type="radio"/> Home Health Agency

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Benlysta	<input type="radio"/> 120 mg 5 ml vial <input type="radio"/> 400 mg 20 ml vial	Dose: _____ mg/kg Total Dose: _____ mg <input type="radio"/> Infuse IV over 1 hour every 2 weeks x 3 doses then every 4 weeks thereafter. <input type="radio"/> Other: _____		<input type="radio"/> 1 year

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

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.