EVALUATION OF USE OF BELIMUMAB IN CLINICAL PRACTICE SETTINGS
PATIENT CASE RECORD FORM

IMPORTANT REMINDER: Medical chart must pertain to a patient meeting **all** of the following requirements:

PATIENT CASE RECORD FORM SELECTION CRITERIA	CHECK
Diagnosed with **systemic lupus erythematosus (SLE)**	☐1 Yes ☐2 No
Adult ≥ 18 years of age	☐1 Yes ☐2 No
Prescribed Benlysta® (Belimumab) and has received at least 8 infusions to date	☐1 Yes ☐2 No
Not currently enrolled in any SLE-related clinical trial	☐1 Yes ☐2 No
Has at least 6 months of medical history prior to Benlysta® (Belimumab) initiation on file with you	☐1 Yes ☐2 No

➔ **ASSIGN A UNIQUE 4-DIGIT IDENTIFICATION FOR THIS PATIENT CHART:** _____ _____ _____ _____

SECTION I: PATIENT PROFILE

1. Specify the following demographic information for this patient:

a. **Gender:** ☐1 Male ☐2 Female

b. **Current weight:** _____ ☐1 lbs ☐2 kg

c. **Race/ethnicity:** ☐1 Caucasian ☐3 African American/Black ☐5 Asian ☐2 Hispanic ☐4 Native American ☐X Other **(SPECIFY)**: _____

d. **Current age:** _____ **Years**

e. **Current height:** _____ **Inches**

2. What is this patient's current employment status?

☐1 Full-time ☐2 Part-time ☐3 Unemployed ☐4 Retired ☐X Other **(SPECIFY)**: _____

3. Did patient receive a flu shot in the past 12 months? ☐1 Yes ➔**Date:** Mo___ Day___ Yr___ ☐2 No ☐0 Don't know

4. Specify below all co-morbid conditions this patient currently has.

☐0	**NONE** – No co-morbid conditions	➔ **GO TO SECTION II**

CONCOMITANT DISEASES / CONDITIONS "X" ALL THAT APPLY			
☐1	Anxiety	☐11	Liver disease / problems
☐2	Asthma	☐12	Lupus nephritis
☐3	Chronic obstructive pulmonary disease (COPD)	☐13	Neuropsychiatric Lupus
☐4	Congestive heart failure (CHF)	☐14	Other renal diseases (non-lupus) / End Stage Renal Disease (ESRD)
☐5	Coronary artery disease (CAD)	☐15	Osteoporosis
☐6	Depression	☐16	Osteoarthritis
☐7	Diabetes (Type II)	☐17	Rheumatoid arthritis
☐8	Hyperlipidemia	☐18	Sjogren's syndrome
☐9	Hypertension	☐19	Vasculitis
☐10	Fibromyalgia		Other **(SPECIFY)**: _____

SECTION II: SLE DIAGNOSIS INFORMATION AND HISTORY

1. When was SLE diagnosed in this patient? ("X" one only)

☐$_1$ <1 yr ☐$_2$ 1-5 yrs ☐$_3$ 6-10 yrs ☐$_4$ >10 yrs ☐$_0$ Don't know

2. Did you diagnose this patient? ☐$_1$ Yes ➔ **Continue** ☐$_2$ No ➔ **Skip to Q3**

a. Did you use any **disease activity assessment tools** to assess disease activity at the time of initial diagnosis?

☐$_2$ No ☐$_1$ Yes ➔ **If Yes**, please indicate the assessment tool(s) used: **("X" all that apply)**

☐$_1$ Physician Global Assessment Scale
☐$_2$ Patient Global Assessment Scale
☐$_3$ SELENA-SLEDAI (Systemic Lupus Erythematosus Disease Activity Index SELENA Modification) / SLEDAI
☐$_4$ BILAG (British Isles Lupus Assessment Group Index)
☐$_5$ SLAM (Systemic Lupus Activity Measure)
☐$_6$ ECLAM (European Consensus Lupus Activity Measurement Index)
☐$_x$ Other **(SPECIFY)**: _____

b. Did you use any **other assessment tools** at the time of initial diagnosis?

☐$_2$ No ☐$_1$ Yes ➔ **If Yes,** indicate the assessment tool(s) used: **("X" that apply)**

☐$_7$ Fatigue Severity Scale
☐$_x$ Other **(SPECIFY)**: _____

3. What was the severity of patient's SLE disease at the time of initial diagnosis? ("X" one only)

☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe ☐$_0$ Don't Know

SECTION III: BELIMUMAB THERAPY

1. Did the patient have any of the following characteristics at the start of belimumab therapy? [Please "X" all that apply}

☐$_1$ Low C3 (< Lower Limit of Normal) ☐$_4$ Proteinuria (>Upper Limit of Normal) ☐$_6$ Thrombocytopenia
☐$_2$ Low C4 ((< Lower Limit of Normal) ☐$_5$ Leukopenia ☐$_7$ Hemolytic anemia
☐$_3$ High ds-DNA

2. Specify date of belimumab therapy START: Mo_____ Day_____ Yr_____

3. Specify reasons for starting patient on belimumab therapy: ("X" all that apply)

☐$_1$ Patient condition worsening
☐$_2$ Previous treatment regimen not effective
☐$_3$ Previous treatment regimen not well tolerated
☐$_4$ Decrease use of steroids (steroid sparing)
☐$_5$ Previous treatment regimen inconvenient
☐$_6$ Drug-to-drug interactions with previous medication
☐$_7$ Patient request
☐$_X$ Other **(SPECIFY)**: _____

4. Specify the STARTING DOSE of belimumab: _____ mg/kg

5. Any CHANGES to belimumab dose in the first 6-months of use? ☐$_1$ Yes ☐$_2$ No ➔ **Skip to Q6**

If Yes: **Date:** Mo____ Day____ Yr_____ **New Dose:** _____mg/kg

6. What was your overall clinical assessment of severity of patient's SLE disease at the time of belimumab start?

☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe ☐$_0$ Don't Know

7. a. Specify all disease activity assessments performed for this patient at the start of belimumab treatment and/or at 6 months after belimumab start (+6 months). ➔ For each assessment specified, indicate the score.

☐$_0$ **No disease activity assessments performed ➔ Skip to Q8**

ASSESSMENTS/TESTS ["x" all that apply]:	Score at Belimumab Start	Score at +6 Months
☐$_1$ Physician Global Assessment Scale ➔**Specify range of scale used: ___ to ___**	_______	_______
☐$_2$ Patient Global Assessment Scale ➔ **Specify range of scale used: ___ to ___**	_______	_______
☐$_3$ SELENA-SLEDAI (Systemic Lupus Erythematosus Disease Activity Index SELENA Modification)/SLEDAI	_______	_______
☐$_4$ BILAG (British Isles Lupus Assessment Group Index)	_______	_______
☐$_5$ SLAM (Systemic Lupus Activity Measure)	_______	_______
☐$_6$ ECLAM (European Consensus Lupus Activity Measurement Index)	_______	_______
☐$_x$ Other (**SPECIFY**): ______________	_______	_______

b. Did you use any other assessment tools at the start of belimumab treatment and/or at 6 months after belimumab start (+6 months)?

☐$_2$ No ➔ **Skip to Q.8** ☐$_1$ Yes ➔ **If Yes, Yes**, please indicate the assessment tool(s) used: **("X" one only)**

	Score at Belimumab Start	Score at +6 Months
☐$_7$ Fatigue Severity Scale ➔ **Please normalize the scale/score to a range of 0-100 and provide your assessment**	________	________
☐$_x$ Other (**SPECIFY**): ______________	________	________

8. In table below specify the:

a) **SLE Clinical manifestations** this patient presented with at time of belimumab **therapy START**.
(WRITE IN # CODES FROM LEGEND SHEET. USE ONE ROW FOR EACH CLINICAL MANIFESTATION)

b) **Severity** of each clinical manifestation present at time of belimumab therapy **start.**

c) **Percent improvement** from baseline (=start of belimumab therapy) at **six months** of belimumab therapy
Percent improvement from baseline (=start of belimumab therapy) at **end of** belimumab therapy **OR most recent assessment**

(a)	(b)	(c)
Clinical Manifestations of SLE At Belimumab Therapy Start *(Use # Codes In Legend Sheet)*	**Severity of Each Clinical Manifestation at Belimumab Therapy Start**	**% Improvement from Baseline at 6 Months**
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Code #: ________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Other (**SPECIFY**): ___________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%
Other (**SPECIFY**): ___________	☐$_1$ Mild ☐$_2$ Moderate ☐$_3$ Severe	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%

9. Based on your clinical impression, specify this patient's overall clinical response to belimumab therapy at 6 months from start of belimumab:

	% Improvement at 6 Months from Belimumab Start Date
Overall Clinical Response to belimumab Treatment (clinician impression of overall clinical manifestation(s) observed)	☐$_1$ Worse ☐$_2$ No Improvement ☐$_3$ <20% ☐$_4$ 20-49% ☐$_5$ 50-79% ☐$_6$ ≥80%

SECTION IV: OTHER SLE THERAPY

1. Specify all other SLE medications this patient has ever been prescribed for the treatment of SLE PRIOR to starting belimumab: ("X" all that apply)

☐1 Abatacept / Orencia	☐10 IV steroids (e.g., Methylprednisolone)
☐2 Adalimumab / Humira	☐11 Methotrexate (MTX)
☐3 Antimalarials (e.g., hydroxychloroquine, chloroquine)	☐12 Mycophenolate mofetil / CellCept
☐4 Azathioprine / AZA / Imuran	☐13 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
☐5 Cyclophosphamide / Cytoxan	☐14 Oral steroids (Prednisone, methylprednisolone, etc.)
☐6 Cyclosporine / Neoral, Sandimmune, Gengraf	☐15 Rituximab / Rituxan
☐7 Dapsone	☐16 Thalidomide
☐8 Etanercept / Enbrel	☐17 Tocilizumab / Actemra
☐9 Infliximab / Remicade	☐xx Other (specify):_____

2. Specify ALL SLE medications other than belimumab this patient received/was on during the last 6 months before the belimumab therapy start date AND/OR during first 6 months after the start date of belimumab. Check "NONE" if patient did not receive any SLE medications other than belimumab during these time periods.

☐0 **NONE:** No SLE medications other than belimumab received in 6 months prior/post belimumab start → **GO TO SECTION V**

Medication *(use Legend # codes)* _____ **Start Date:** Mo____ Day____ Yr____

	Dose per Administration	Route of Administration	Frequency
At time of medication start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
At time of belimumab initiation	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
6 Months from belimumab start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
Discontinued within 6 months of belimumab start? ☐2 No ☐1 Yes ↓ End Date: M____ D____ Y_____ ***Specify details when ended →***	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____

Medication *(use Legend # codes)* _____ **Start Date:** Mo____ Day____ Yr____

	Dose per Administration	Route of Administration	Frequency
At time of medication start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
At time of belimumab initiation	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
6 Months from belimumab start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
Discontinued within 6 months of belimumab start? ☐2 No ☐1 Yes ↓ End Date: M____ D____ Y_____ ***Specify details when ended →***	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____

CONTINUED: Specify all SLE medications other than belimumab this patient received during the last 6 months before the Belimumab therapy start date AND/OR during first 6 months after the start date of belimumab therapy.

Medication *(use Legend # codes)* ___________ **Start Date:** Mo____ Day____ Yr____

	Dose per Administration	Route of Administration	Frequency
At time of medication start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐$_1$ Daily ☐$_2$ BID ☐$_3$ TID ☐$_4$ Once a week ☐$_5$ Every 2 weeks ☐$_6$ Every 3 weeks ☐$_7$ Every 4 weeks ☐$_x$ Other:_______
At time of belimumab initiation	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
6 Months from belimumab start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
Discontinued within 6 months of belimumab start? ☐$_2$ No ☐$_1$ Yes ↓ End Date: M____ D____ Y_____ ***Specify details when ended →***	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______

Medication *(use Legend # codes)* ___________ **Start Date:** Mo____ Day____ Yr____

	Dose per Administration	Route of Administration	Frequency
At time of medication start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐$_1$ Daily ☐$_2$ BID ☐$_3$ TID ☐$_4$ Once a week ☐$_5$ Every 2 weeks ☐$_6$ Every 3 weeks ☐$_7$ Every 4 weeks ☐$_x$ Other:_______
At time of belimumab initiation	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
6 Months from belimumab start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
Discontinued within 6 months of belimumab start? ☐$_2$ No ☐$_1$ Yes ↓ End Date: M____ D____ Y_____ ***Specify details when ended →***	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______

Medication *(use Legend # codes)* ___________ **Start Date:** Mo____ Day____ Yr____

	Dose per Administration	Route of Administration	Frequency
At time of medication start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐$_1$ Daily ☐$_2$ BID ☐$_3$ TID ☐$_4$ Once a week ☐$_5$ Every 2 weeks ☐$_6$ Every 3 weeks ☐$_7$ Every 4 weeks ☐$_x$ Other:_______
At time of belimumab initiation	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
6 Months from belimumab start	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______
Discontinued within 6 months of belimumab start? ☐$_2$ No ☐$_1$ Yes ↓ End Date: M____ D____ Y_____ ***Specify details when ended →***	_______ ☐$_1$ mg ☐$_2$ mg/kg ☐$_x$ Other: ____	☐$_1$ Oral ☐$_2$ IV ☐$_3$ IM ☐$_x$ Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_______

CONTINUED: Specify all SLE medications other than belimumab this patient received during the last 6 months before the Belimumab therapy start date AND/OR during first 6 months after the start date of belimumab therapy.

Medication *(use Legend # codes)* _____ **Start Date:** Mo____ Day____ Yr____			
	Dose per Administration	**Route of Administration**	**Frequency**
At time of medication start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
At time of belimumab initiation	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
6 Months from belimumab start	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____
Discontinued within 6 months of belimumab start? ☐2 No ☐1 Yes ➔ End Date: M____ D____ Y_____ ***Specify details when ended*** ➔	_____ ☐1 mg ☐2 mg/kg ☐x Other: ____	☐1 Oral ☐2 IV ☐3 IM ☐x Other:_____	☐1 Daily ☐2 BID ☐3 TID ☐4 Once a week ☐5 Every 2 weeks ☐6 Every 3 weeks ☐7 Every 4 weeks ☐x Other:_____

SECTION V: NON-SLE THERAPY

1. Specify NON-SLE therapies used for this patient and timing of therapy relative to belimumab start date:

NON-SLE Therapies / Meds Ever Used [“x” all that apply]	**Used During Last 6-Months Before Belimumab Start Date**	**Used During First 6-Months After Belimumab Start Date**
☐1 Antidepressants	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐2 Anxiolytics	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐3 Narcotic Pain Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐4 Osteoporosis Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐5 Cholesterol lowering Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐6 Antihypertensive Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐7 Diabetes Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐8 Hormone therapy	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐9 Allergy Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐10 Seizure Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐11 Gastrointestinal Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐12 Sleep Disorder Meds	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐x Other:_____	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐x Other:_____	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐x Other:_____	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know
☐x Other:_____	☐1 Yes ☐2 No ☐0 Don’t know	☐1 Yes, ☐2 No, ☐0 Don’t know

SECTION VI: RESOURCE UTILIZATION RELATED TO SLE

1. Write in the number of <u>scheduled and unscheduled visits</u> related to SLE this patient had to your office within each of the two time periods specified (Last 6-months before vs. First 6-months after belimumab start):

PATIENT VISITS TO YOUR OFFICE	In Last 6-months Before Belimumab Start Date (ENTER '0' IF NONE DOCUMENTED)	In First 6-months After Belimumab Start Date (ENTER '0' IF NONE DOCUMENTED)
Your Office:		
# of **<u>Scheduled</u>** visits to your office	# of visits: ____	# of visits: ____
# of **<u>Unscheduled</u>** visits to your office	# of visits: ____	# of visits: ____

2. For each of the specified time periods (Last 6-months before vs. First 6-months after belimumab start), indicate all other physicians this patient visited for SLE-related reasons. Write in the number of visits for each specialty seen:

OTHER PHYSICIANS VISITED ["x" all that apply]	In Last 6-months Before Belimumab Start Date (ENTER '0' IF NONE DOCUMENTED)	In First 6-months After Belimumab Start Date (ENTER '0' IF NONE DOCUMENTED)
☐$_1$ Another Rheumatologist	# of visits: ____	# of visits: ____
☐$_2$ Allergist	# of visits: ____	# of visits: ____
☐$_3$ Cardiologist	# of visits: ____	# of visits: ____
☐$_4$ Dermatologist	# of visits: ____	# of visits: ____
☐$_5$ Gastroenterologist	# of visits: ____	# of visits: ____
☐$_6$ Internist	# of visits: ____	# of visits: ____
☐$_7$ Nephrologist	# of visits: ____	# of visits: ____
☐$_8$ Neurologist	# of visits: ____	# of visits: ____
☐$_9$ Ophthalmologist	# of visits: ____	# of visits: ____
☐$_{10}$ Psychologist	# of visits: ____	# of visits: ____
☐$_{11}$ Radiologist	# of visits: ____	# of visits: ____
☐$_{xx}$Other (Please Specify): _____	# of visits: ____	# of visits: ____
☐$_{xx}$Other (Please Specify): _____	# of visits: ____	# of visits: ____

3. Has this patient had at least one <u>SLE-related Emergency Room (ER)</u> visit in the last 6-months before the start date of belimumab AND/OR during the first 6-months after the start date of belimumab treatment? ("X" one only)

☐$_2$ No ➔ **Skip to Q.4** ☐$_1$ Yes ➔ **Write in below the number of ER visits for each period of time specified:**

	In Last 6-months Before Belimumab Start Date	In First 6-months After Belimumab Start Date
Emergency Room (ER) Visits related to SLE	# of ER visits: ____	# of ER visits: ____

4. Has this patient had at least one SLE-related hospitalization in the last 6-months before the start date of belimumab and/or during the first 6-months after the start date of belimumab treatment? ("X" one only)

☐$_2$ No ➔ **Skip to Q.5** ☐$_1$ Yes ➔ **Write in table below the details for each hospitalization:**

	Hospitalization # 1	Hospitalization # 2	Hospitalization # 3	Hospitalization # 4
Admission date	Mo____ Day____ Yr____	Mo____ Day____ Yr____	Mo____ Day____ Yr____	Mo____ Day____ Yr____
# of days spent in hospital	# ____	# ____	# ____	# ____
Admitted to ICU	☐$_1$ Yes➔# of days:____ ☐$_2$ No	☐$_1$ Yes➔# of days:____ ☐$_2$ No	☐$_1$ Yes➔# of days:____ ☐$_2$ No	☐$_1$ Yes➔# of days:____ ☐$_2$ No

5. Did this patient receive any SLE-related ancillary care in the last 6-months before the start date of belimumab and/or during the first 6-months after the start date of belimumab treatment? ("X" one only)

☐$_1$ Yes ➔ **Complete table below** ☐$_2$ No ➔ **Skip to Q.6**

ANCILLARY CARE	In Last 6-months Before Belimumab Start Date	In First 6-months After Belimumab Start Date
Physical therapy	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know
Occupational therapy	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know
Home health care services	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know
Other (Specify): _____	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know	☐$_1$ Yes ☐$_2$ No ☐$_0$ Don't know

6. Specify patient's primary and secondary major medical (Column A) and drug insurance (Column B) coverage in the table below.

	Column A: Medical Insurance Coverage		Column B: Drug Insurance Coverage	
	Primary	Secondary	Primary	Secondary
Medicare (including office injection)	☐$_1$	☐$_1$	☐$_1$	☐$_1$
Medicaid	☐$_2$	☐$_2$	☐$_2$	☐$_2$
State Funded Program	☐$_3$	☐$_3$	☐$_3$	☐$_3$
Traditional Fee For Service/Indemnity Insurance	☐$_4$	☐$_4$	☐$_4$	☐$_4$
HMO	☐$_5$	☐$_5$	☐$_5$	☐$_5$
PPO	☐$_6$	☐$_6$	☐$_6$	☐$_6$
Self Pay	☐$_7$	☐$_7$	☐$_7$	☐$_7$
Indigent / No Pay	☐$_8$	☐$_8$	☐$_8$	☐$_8$
VA	☐$_9$	☐$_9$	☐$_9$	☐$_9$
None	☐$_0$	☐$_0$	☐$_0$	☐$_0$
Don't Know / Not documented	☐$_{98}$	☐$_{98}$	☐$_{98}$	☐$_{98}$

END OF THIS PATIENT CHART FORM