

Benlysta (Belimumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg | 650mg | 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg | 50mg | PO | IV
 methylprednisolone (Solu-Medrol) 40mg | 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

Belimumab (Benlysta) in 250ml 0.9% sodium chloride, intravenous infusion over one hour

- Dose: 10mg/kg
- Route: intravenous
- Frequency: induction: week 0, 2, and 4, then every 4 weeks/
 maintenance: every 4 weeks / other: _____

- Infuse over one hour
- Flush with 0.9% sodium chloride at infusion completion

Belimumab (Benlysta) injection

- Dose: 200mg
- Frequency: once weekly
- Route: subcutaneous

Patient is required to stay for 30-minute observation
 Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

* Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print)

Provider Signature

Date