Local Infusion

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BENLYSTA (BELIMUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy | Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Systemic Lupus Erythramostus, ICD 10: M32. _____

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Benlysta	10 mg/kg	IV	❑ Every 2 weeks x 3 doses, then every 4 weeks ❑ Every 4 weeks

LABS / SPECIAL INSTRUCTIONS