

# Benlysta (Belimumab)

## 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

### 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