Belimumab (Benlysta)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Systemic lupus erythematosus:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer belimumab 10 mg/kg x (current weight) _____________ kg = _____________ mg in 250 mL 0.9% sodium chloride over 60 minutes. If patient weighs less that 40kg dilute to 100ml NS.

☑ Patient will be monitored for 60 minutes post-infusion following the first three treatments and for 30 minutes post-infusion for all subsequent treatments.

FREQUENCY *(Choose one)*

☐ Induction: Week 0, Week 2, Week 4, then every 4 weeks
☐ Maintenance: every 4 weeks
☐ Every _____ weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: ________________________________

NURSING

☑ Hold infusion and notify provider for:

- Abnormal vital signs
- Signs or symptoms of illness or active infection
- Planned/recent surgical procedures.
- Recent live vaccinations
- New/worsening neurological symptoms or mood changes

☑ Document measured weight at each appointment.

☑ Record vital signs before infusion, then every 30 minutes until patient discharge.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with steroids and immunosuppressants

Required Labs: ANA, anti-dsDNA, Anti-SM, Anti-RO/SSA, Anti-LA/SSB, CRP, ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.