

(belimumab)

# BENLYSTA infusion orders

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone \_\_\_\_\_ M ☐ F ☐

☐ Allergies \_\_\_\_\_

NPI \_\_\_\_\_ Tax ID \_\_\_\_\_

Insurance Carrier (primary) \_\_\_\_\_

Insurance Carrier (secondary) \_\_\_\_\_

## DIAGNOSIS Please provide ICD-10 code

☐ \_\_\_\_\_ Systemic Lupus Erythmatosus

☐ \_\_\_\_\_ (other)

## REFERRAL STATUS

☐ New Prescription

☐ Order Renewal

☐ Does or Frequency Change

☐ Discontinuation

## PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ \_\_\_\_\_ (other)

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ \_\_\_\_\_ (other)

## BENLYSTA ORDERS

### DOSAGE

☒ 10mg/kg IV

☐ Other \_\_\_\_\_

### PATIENT WEIGHT

\_\_\_\_\_ lbs.

\_\_\_\_\_ kg

### FREQUENCY

☐ Dose at weeks 0, 2, and 4, then every 4 weeks

☐ Dose every 4 weeks

Total dosage: \_\_\_\_\_

NOTES

## ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_