

(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 _____