Palmetto Infusion Services COMPLIANCE

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD Benlysta® (belimumab) PLAN OF TREATMENT

(Re) Certification Period From_____to _____

NOTE: Patient ***may be ineligible*** to receive belimumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies:_____

3. Diagnosis: ☐ **M32.10 Systemic lupus erythematosus, organ or system involvement unspecified**

☐ Other **ICD-10 Code**: _____**Diagnosis description:** _____

4. Pre-medications: ☐ None ***OR*** ***Administered 30 minutes prior to infusion as selected:***

****Product information suggests premedication prior to infusion. Suggest caution with use of Diphenhydramine due to 60-minute infusion time and safety risks with driving.***

Acetaminophen: □ 650 mg PO □ 500 mg PO □ 325 mg PO	Diphenhydramine: □ 25 mg PO, □ 50 mg PO, □ 25 mg IVP, □ 50 mg IVP or Fexofenadine □ 60mg or □ 180 mg, □ Cetirizine 10 mg, □ Loratadine 10 mg Methylprednisolone □ 40 mg IVP □ 125 mg IVP or other _____mg IVP Famotidine: □ 20 mg PO, □ 40 mg PO, □ 20 mg IVP, □ 40 mg IVP

Pre-medicate with other: _____

Orders: Benlysta® (belimumab) 10mg/kg per 250 ml Sodium Chloride 0.9% IV to infuse over at least 60 minutes

5. Frequency:

☐ Induction orders to be completed at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter

☐ Maintenance orders every 4 weeks (No < 28 days)

Special Orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature: _____/ _____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 5/25/18

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DOB:_____

Guidelines for Prescribing Benlysta® (belimumab)

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date:_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Any lab results to include positive autoantibody results such as Anti-dsDNA (antibodies to DNA), Antinuclear antibody (ANA), Anti-RNP, Anti-Smith. Other tests as available: skin/kidney biopsies to support diagnosis and SELENA-SLEDA Score.**

- BENLYSTA® is indicated for the treatment of adult patients with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy.

___ If patient is switching therapies such as Rituxan (rituximab) or Cytoxan (cyclophosphamide), then MD must specify wash-out period prior to starting Benlysta® as specified of _____ weeks and specify last known date received: _____. (Include copy of last Benlysta® infusion record if available and currently on therapy)

___ Other as requested: _____
_____
_____

Pre-Screening:

___ **Required positive autoantibody results such as Anti-dsDNA (antibodies to DNA), Antinuclear antibody (ANA), Anti-RNP, Anti-Smith.**

** Warnings/Precautions: **Serious Infections:** Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents, including BENLYSTA®. Use with caution in patients with severe or chronic infections. Consider interrupting therapy with BENLYSTA® if patients develop a new infection during treatment. **Progressive Multifocal Leukoencephalopathy (PML):** Patients presenting with new-onset or deteriorating neurological signs & symptoms should be evaluated for PML by an appropriate specialist. If PML is confirmed, consider discontinuation of therapy. **Limitations of Use:** The efficacy of BENLYSTA® has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. BENLYSTA® has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of BENLYSTA® is not recommended in these situations. **Evaluation of immunizations should be completed prior to and live vaccines should not be given for 30 days before or concurrently with BENLYSTA®.** See full prescribing information

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 5/25/18