



MRN: _____
 DOB: _____

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

STANDARD Benlysta® (belimumab) PLAN OF TREATMENT

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: <input type="checkbox"/> 650 mg PO <input type="checkbox"/> 500 mg PO <input type="checkbox"/> 325 mg PO	Diphenhydramine: <input type="checkbox"/> 25 mg PO, <input type="checkbox"/> 50 mg PO, <input type="checkbox"/> 25 mg IVP, <input type="checkbox"/> 50 mg IVP or Fexofenadine <input type="checkbox"/> 60mg or <input type="checkbox"/> 180 mg, <input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg Methylprednisolone <input type="checkbox"/> 40 mg IVP <input type="checkbox"/> 125 mg IVP or other _____mg IVP Famotidine: <input type="checkbox"/> 20 mg PO, <input type="checkbox"/> 40 mg PO, <input type="checkbox"/> 20 mg IVP, <input type="checkbox"/> 40 mg IVP
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Pre-medicate with other: _____

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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



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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.