MRN:_____

DOB:_____

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**

☐ **M23.14 Glomerular disease in systemic lupus erythematosus**

☐ **M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus**

☐ **Other: ICD-10 Code: _____ Description:**_____

4. Pre-medications: ***Administered 30 minutes prior to infusion as selected:***

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 10mg 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: _____

5. 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

☐ Maintenance orders every 4 weeks

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: _____

Revised
04/06/2021

MRN:_____

DOB:_____

Guidelines for Prescribing Benlysta® (belimumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ 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

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.