

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Benlysta® (belimumab) Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight:	LB or KG	Gender:
			Allergies:
			See list
			NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

M32.10 - Systemic lupus erythematosus, organ or system involvement
M32.14 - Glomerular disease in systemic lupus erythematosus
M32.15 - Tubulo-interstitial nephropathy in systemic lupus erythematosus
- Other:

### REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	
5	Positive autoantibody results such as Anti-dsDNA (antibodies to DNA), Antinuclear antibody (ANA), Anti-RNP, Anti-Smith.	THERAPY:	
			<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

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.

#### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	25mg	50mg	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

#### MEDICATION/DOSE:

Benlysta® (belimumab) 10mg/kg per 250ml NS

#### FREQUENCY:

Induction orders to be completed at 0 week, 2 week, and 4 weeks

Maintenance orders every 4 weeks

Other: \_\_\_\_\_

#### SPECIAL/LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

Refills x 12 months unless noted otherwise here:

### LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted