

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 2ND AND 3RD 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	
	THERAPY:	IF ORDER CHANGE:
		Continue current order until insurance approved

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		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		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 IV NS to be infused over 1 hour.

FREQUENCY: SPECIAL/LAB ORDERS:

<input type="checkbox"/> Induction orders to be completed at 0 week, 2 week, and 4 weeks	<input type="checkbox"/>
<input type="checkbox"/> Maintenance orders every 4 weeks	
<input type="checkbox"/> Other: _____	

Refills x 12 months unless noted otherwise here:

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

<input checked="" type="checkbox"/> Start PIV/Access CVC	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
<input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	
<input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	

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