


BENLYSTA® (BELIMUMAB) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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BENLYSTA® (BELIMUMAB) Prescription**BENLYSTA® (BELIMUMAB) refill as directed x 1 year****Loading Dose:** IV: Infuse 10mg/kg over 1 hour every 2 weeks for 3 doses.**Maintenance Dose:** IV: Infuse 10mg/kg over 1 hour every 4 weeks**Ancillary Orders****Anaphylaxis Kit**

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
 - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
 - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
- Other: _____

IV Flush Orders

- Peripheral:** NS 2 to 3 mL pre-/post-use.
- Implanted Port:** NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- No labs ordered at this time.
- Other: _____

Refill above ancillary orders as directed x 1 year.

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide 60-minute post-infusion monitoring. Nurse will provide ongoing support as needed.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.***Prescriber Signature:** _____ **Date:** _____**Prescriber Information**

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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