BENLYSTA® (BELIMUMAB) PRESCRIBER ORDER FORM					
Patient Name:	Date of	Date of Birth:			
Address:					
Phone:		Hoight	□ inches □ cn	weight:	🗆 lbs 🗆 kg
Phone.		Height:		weight.	
Clinical Information Primary Diagnosis Description: ICD-10 Code:					
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. 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. 					
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 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. Implanted Port: 0.9% Sodium Chloride 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:					
	Prescrib	er Information			
Prescriber Name:		Phone:		Fax:	
Address:		NPI:			
City, State:	Zip:	Office Contact:	e Contact:		
Fax completed form, insurance information, and clinical documentation to:					
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