

## BENLYSTA (BELIMUMAB) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

### DIAGNOSIS (Provider must specify)

Systemic Lupus Erythramostus, ICD 10: M32. \_\_\_\_\_

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

### PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

### PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone

Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO    (Solu-Medrol) 125 mg IVP

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Benlysta	<input type="checkbox"/> 10 mg/kg	<input type="checkbox"/> IV	<input type="checkbox"/> Every 2 weeks x 3 doses, then every 4 weeks <input type="checkbox"/> Every 4 weeks

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

### LABS / SPECIAL INSTRUCTIONS