

## BENLYSTA (belimumab) ORDER FORM

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ WT: \_\_\_\_\_ HT: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

### DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: BENLYSTA (belimumab) ☐ NO ☐ YES

BRAND: \_\_\_\_\_ LAST DOSE DATE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ ICD 10 CODE(S): \_\_\_\_\_

### MEDICATION ORDERS

Orders are valid for 1 year. For a shorter duration, indicate here: \_\_\_\_\_

#### DOSE:

- ☐ 10 mg/kg IV  
☐ Other: \_\_\_\_\_

#### FREQUENCY:

- ☐ Every 2 weeks for first 3 doses, then every 4 weeks  
☐ Every 4 weeks  
☐ Other: \_\_\_\_\_

#### PREMEDICATIONS: (30 minutes prior to infusion)

- ☐ Acetaminophen 1000 mg PO  
☐ Acetaminophen 500 mg PO  
☐ Methylprednisolone 100 mg IV  
☐ Famotidine 20 mg IV

- ☐ Diphenhydramine 25 mg PO  
☐ Diphenhydramine 50 mg PO  
☐ Cetirizine 10 mg PO  
☐ Other: \_\_\_\_\_

### STANDARD IV ORDERS

#### ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

#### NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for 30 minutes after completion of therapy.

### LABS

#### LAB ORDERS:

- ☐ CBC w/diff  
☐ CMP  
☐ Other: \_\_\_\_\_

#### LAB FREQUENCY:

- ☐ Every dose  
☐ Other: \_\_\_\_\_

### REQUIRED DOCUMENTATION

#### REQUIRED CLINICAL DOCUMENTS:

- None

#### RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline labs: CBC w/diff, CMP
- Depression screening

#### SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

### PROVIDER INFORMATION

\_\_\_\_\_  
PRESCRIBER SIGNATURE (substitution)

\_\_\_\_\_  
PRESCRIBER SIGNATURE (dispense as written)

\_\_\_\_\_  
PRINT NAME (FIRST AND LAST)

\_\_\_\_\_  
DATE