BENLYSTA® (BELIMUMAB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

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) SUBQ 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

☐ **Peripheral:** 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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

