

NPI# _____
DEA# _____

Fax Orders: 702-697-2107



(belimumab)

BENLYSTA infusion orders

Patient Name _____

DOB _____

Phone _____

M

F

DIAGNOSIS Please provide ICD-10 code

Systemic Lupus Erythematosus

(other) _____

PRE-MEDICATION

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

(other) _____

(other) _____

BENLYSTA ORDERS

DOSAGE

10 mg/kg IV

PATIENT WEIGHT

lbs.

FREQUENCY

Dose at weeks, 0,2, and 4, then every 4 weeks

Dose every 4 weeks

kg

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____

Phone _____

Fax _____

Address: _____
