(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

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

☐ Length of Need _____

## BENLYSTA ORDERS

### DOSAGE

◯ 10 mg/kg IV

### FREQUENCY

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

◯ Dose every 4 weeks

### PATIENT WEIGHT

_____ lbs.

_____ kg

◯ Refills: _____

**Notes**

_____

## ORDERING PROVIDER

Signature **X** Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

**FAX ORDERS: 702-780-4887**