



INFUSION ORDERS-BENLYSTA (BELIMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Autoantibody-Positive, Systemic Lupus Erythematosus (SLE) ICD 10 Code: M32.9 <input type="checkbox"/> Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Pregnancy Test (if applicable) <input type="checkbox"/> ANA (anti-nuclear Ab) and/or anti-dsDNA Test Results
List Tried & Failed Therapies, including duration of treatment:
1)
2)

MEDICATION ORDERS	
Initial dosing	<input type="checkbox"/> Benlysta 10 mg/kg IV at Week 0, 2, 4 then every 4 weeks thereafter** <input type="checkbox"/> Benlysta _____ mg IV at Week 0, 2, 4 then every 4 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Benlysta 10mg/kg IV every 4 weeks** <input type="checkbox"/> Benlysta _____ mg IV every 4 weeks
Patient's Most Recent Weight = _____ kg	
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses (all doses including initial loading)

** Patient weight is required for all weight-based orders.

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO, 30-60 minutes prior to Benlysta infusion <input type="checkbox"/> Diphenhydramine 25mg PO, 30-60 minutes prior to Benlysta infusion (recommended by manufacturer) <input type="checkbox"/> Methylprednisolone 100mg Slow IV Push PRN infusion reaction <input type="checkbox"/> Other:

OTHER TESTING (Optional)
<input type="checkbox"/> Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627

Fax completed form and all documentation to (866) 507-1164

All information contained in this form is strictly confidential and will become part of the patient's medical record.