(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)*

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

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.