FLOMED INFUSION

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BENLYSTA (belimumab)

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________ Phone: ______________
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name: ______________________ Provider NPI: ______________

Practice Address: ______________________ City: ______________ State: ________ Zip: ________

Practice Name: ______________________

Practice Phone: ______________ Fax: ______________ Contact Person: ______________

MEDICAL INFORMATION

Patient Weight: ________ Patient Height: ________ ICD-10 Code (required): ______________ ICD-10 Description: ______________

Known Allergies: ______________________
Required Labs: ______________________

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: ______________
- Date of last ANA test: ______________

BENLYSTA (belimumab) ORDERS

Initial Dose: ☐ 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter
Maintenance Dose: ☐ 10mg/kg IV every 28 days

Protocol: ☐ Tylenol 1000mg PO
Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional: ☐ Solu-Medrol ______________mg IVP
☐ Solu-Cortef ______________mg IVP

Additional Orders/Comments: ______________________

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: ______________________ Print Name: ______________ Date: ______________