Ascension Rx

Belimumab (Benlysta) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs

☐ Other: _____

Nursing Orders

☑ If hypersensitivity reaction occurs, then stop infusion, notify the provider and start at a slower rate.

☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

☐ Acetaminophen 650 mg PO once

☐ Diphenhydramine 25 mg PO once

☐ Diphenhydramine 25 mg IV once

☐ Diphenhydramine 50 mg PO once

☐ Diphenhydramine 50 mg IV once

☐ Famotidine 20 mg IV once

☐ Famotidine 20 mg PO once

☐ Dexamethasone 20 mg IV once

☐ Dexamethasone 20 mg PO once

☐ Methylprednisolone 125 mg IV once

☐ Methylprednisolone 40 mg IV once

☐ Other: _____

IV Site Orders

☑ Follow standard protocol for IV site management

☑ In absence of standard protocol, follow the orders below:

- ☑ Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
- ☑ Start peripheral IV or access central line for infusion
- ☑ Sodium chloride 0.9% 10 mL flush to IV site as needed
- ☑ Heparin 50 units/5 mL flush to IV site as needed (central line only)
- ☑ Heparin 500 units/5 mL flush to IV site as needed (central line only)
- ☑ May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

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Medication Orders (select only one)

☐ Belimumab 10 mg/kg (_____mg) IV over 60 minutes once every 2 weeks for a total of 3 doses, followed by Belimumab 10 mg/kg (_____mg) every 4 weeks

☐ Belimumab 10 mg/kg (_____mg) IV over 60 minutes once every 4 weeks

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

Pharmacy may adjust dose ±10% of ordered dose per approved protocol.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated