Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Belimumab (Benlysta) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:	_____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Systemic Lupus Erythematosus ☐ Lupus Nephritis ☐ Other: _____	☑ ICD-10: _____	☑ J0490	☑ CPT Code: _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☑ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☑ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Belimumab	IVPB	10 mg/kg over 1 hour	Once	☐ Initial: Every 2 weeks x 3 doses for _____ dose(s) ☐ Maintenance: Every 4 weeks for _____ dose(s) ☐ Other: _____

Order Comments: Do NOT administer as an IV push or bolus. Withdraw equal volume of NS to the volume of belimumab required for the dose for the final compounded volume 100 mL (for patient weight ≤40 kg) OR 250 mL (for patient weight >40 kg). Protect from light.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.
Administration Instructions:
Discontinue infusion for severe hypersensitivity reaction (eg, anaphylaxis, angioedema).
The infusion may be slowed or temporarily interrupted for minor reactions. Consider premedicating with an antihistamine and antipyretic for prophylaxis against hypersensitivity or infusion reactions.
For subsequent infusions in patients with prior infusion-related reactions, extend infusion to 2 hours.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			