# Belimumab (Benlysta)

***Provider Order Form*** rev. 9/20/2021

IVX HEALTH

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Date: | Patient Name: | | DOB: |
| ICD-10 code (required): | | ICD-10 description: | |
| ☐ NKDA Allergies: | | | Weight lbs/kg: |
| **Patient Status:** ☐ New to Therapy | ☐ Continuing Therapy | Next Due Date (if applicable): | |

## PROVIDER INFORMATION

| | | | |
|---|---|---|---|
| Referral Coordinator Name: | | Referral Coordinator Email: | |
| Ordering Provider: | | Provider NPI: | |
| Referring Practice Name: | | Phone: | Fax: |
| Practice Address: | | City: | State: Zip Code: |

## NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
**NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

## LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

## PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

## THERAPY ADMINISTRATION

☐ **Belimumab** (Benlysta) in 250ml 0.9% sodium chloride, intravenous infusion over one hour
- Dose: 10mg/kg = _____mg
- Route: ☑ intravenous
- Frequency: ☐ induction: week 0, 2, 4, and then every 4 weeks / ☐ maintenance: every 4 weeks / ☐ other: _____
- Infuse over one hour

☑ Flush with 0.9% sodium chloride at infusion completion

☐ **Belimumab** (Benlysta) injection
- Dose: ☐ 200mg
- Frequency: ☐ once weekly
- Route: ☑ subcutaneous

☐ Patient is required to stay for 30-minute observation post infusion/injection
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

**Provider Name (Print)** **Provider Signature** **Date**

**Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:**

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