

# Benlysta® (Belimumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

**Fax completed form, insurance information and clinical documentation to 414-260-7368.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Height: \_\_\_\_\_  inches  cm Weight: \_\_\_\_\_  lbs  kg

## Clinical Information

Primary Diagnosis Description: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

## Benlysta® (Belimumab) Prescription

**Benlysta® (Belimumab)** refill as directed x 1 year

**Loading Dose:**  IV: Infuse 10mg/kg over 1 hour every 2 weeks for 3 doses.

**Maintenance Dose:**  IV: Infuse 10mg/kg over 1 hour every 4 weeks

## Ancillary Orders

### Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

### Medication Orders

Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.

Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.

Other: \_\_\_\_\_

**IV Access and Flush Orders:** RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

### Lab Orders

No lab orders ordered at this time

Other: \_\_\_\_\_

**Refill above ancillary orders as directed x 1 year.**

**Skilled nurse to assess and administer via access device as indicated above. Nurse will provide 60-minute post-infusion monitoring. Nurse will provide ongoing support as needed.**

**I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.**

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ NPI \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Office Contact \_\_\_\_\_



Original - Medical Records

**Froedtert Home and Specialty Infusion**  
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03/25