



BENLYSTA (belimumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: F: Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies: _____

PRIMARY DIAGNOSIS

ICD-10 Code: _____

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

<input type="checkbox"/> Acetaminophen 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Ceterizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> Loratadine 10mg PO	<input type="checkbox"/> Other: _____

PRIMARY MEDICATION ORDER

Dosage:

10 mg/kg IV

Patient Weight:

Frequency:

Dose at weeks 0, 2, and 4, then every 4 weeks
 Dose every 4 weeks

_____ lbs
_____ kg

Benlysta (belimumab) Autoinjector 200 mg/mL Subcutaneous injection once weekly

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____