



5401 Longley Lane, Bldg B, Suite 34
Reno, NV 89511
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Benlysta Infusion Order Form

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Pt Sex: _____ Weight: _____ Height: _____ Pt email: _____

Allergies: _____

DIAGNOSIS:

- Systemic Lupus Erythematosus ICD-10 Code _____
- Lupus Nephritis ICD-10 Code _____
- Other _____ ICD-10 _____

ORDER FOR BENLYSTA (BELIMUMAB):

- Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter x1 year
- Maintenance: 10mg/kg IV every 28 days x1 year
- Other: _____ x 1 year.

PRE-MEDICATIONS:

- Acetaminophen 650mg PO
- Diphenhydramine 25mg PO or IV
- Hydrocortisone 100mg IV
- Methylprednisolone 125mg IV
- Other Pre-meds _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Diphenhydramine 25mg (>30kg) or 1.25mg/kg (≤30 kg) IV or IM, repeat x1 in 15 min PRN no improvement.
- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SQ or IM x1; repeat x1 in 5 to 15 min PRN
- Solu-Medrol 125mg IV x1 dose OR Solu-Cortef 100mg IV x1 dose
- Normal saline 500ml (>30kg) or 250ml (≤kg) IV at KVO rate PRN anaphylaxis. Patients ≤30kg, infuse over 2 to 4 hours PRN headache rated >5 on pain scale
- Administer Oxygen via nasal cannula as needed to keep O2 sats over 90%. Start at 2L/min via nasal cannula and titrate up as needed. Do not exceed 6L/min.

LABS ORDERS: _____ Fax results to: _____

ACCESS: Peripheral IV or _____

FLUSHING: 10 mls NS pre/post infusion and Heparin 5ml for port – 100 units/ml NURSING: Nevada Infusion Nursing

PROVIDER INFORMATION

Practice Name _____

Physician Name: _____ NPI _____

Physician Signature: _____ Date: _____

Contact Person: _____ Phone #: _____ Email: _____

PLEASE FAX THIS FORM WITH PATIENT DEMOGRAPHICS, LABS AND H&P TO 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****