Belimumab (Benlysta)

Provider Order Form rev. 07/30/25

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Systemic lupus erythematosus:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer belimumab 10 mg/kg x (current weight) _____ kg = _____ mg in 250 mL 0.9% sodium chloride over 60 minutes. If patient weighs less that 40kg dilute to 100ml NS.

☑ Patient will be monitored for 60 minutes post-infusion following the first three treatments and for 30 minutes post-infusion for all subsequent treatments.

FREQUENCY *(Choose one)*

☐ Induction: Week 0, Week 2, Week 4, then every 4 weeks

☐ Maintenance: every 4 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ LFT ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Abnormal vital signs
- Signs or symptoms of illness or active infection
- Planned/recent surgical procedures.
- Recent live vaccinations
- New/worsening neurological symptoms or mood changes

☑ Document measured weight at each appointment.

☑ Record vital signs before infusion, then every 30 minutes until patient discharge.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with steroids and immunosuppressants

Required Labs: ANA, anti-dsDNA, Anti-SM, Anti-RO/SSA, Anti-LA/SSB, CRP, ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.