St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Belimumab (BENLYSTA)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.

LABS:

☐ CBC with auto differential, Routine, ONCE, every 90 days

NURSING ORDERS:

1. Patient with active infection should not receive belimumab and should have infusion rescheduled until infection has subsided.
2. Monitor patient for infusion related or hypersensitivity reactions (itching, swelling, difficulty breathing, low blood pressure, anxiousness, headache, nausea, skin rash, etc.).
3. Counsel patients to be aware of hypersensitivity reactions for 2 to 3 hours after first 2 infusions.
4. Vital signs and status at the start of the infusion, every 30 minutes until the end of infusion and when infusion complete.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS (optional):

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(es)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit 30 minutes prior to infusion

☐ diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, ONCE, every visit 30 minutes prior to infusion. **Give either cetirizine or diphenhydrAMINE, not both.**

☐ cetirizine (ZYRTEC), 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit 30 minutes prior to infusion. **Give either cetirizine or diphenhydrAMINE, not both.**

☐ Other _____

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MEDICATIONS:

1. **Select one** of the following dosing schedules:

☐	**Initial Followed by Maintenance:** Infuse belimumab 10 mg/kg IV in 250mL 0.9% sodium chloride over 60 minutes every 2 weeks for the first 3 doses (weeks 0, 2, 4), then every 4 weeks (week 8 and beyond).
☐	**Maintenance only**: Infuse belimumab 10 mg/kg IV in 250mL 0.9% sodium chloride over 60 minutes every 4 weeks.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed