MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

BENLYSTA (BELIMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
❑ New Referral	❑ Dose or Frequency	❑ Change Order Renewal

INFUSION OFFICE PREFERENCE (Optional)		
Preferred Location:	❑ Montgomery	❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Autoantibody-Positive, Systemic Lupus Erythematosus (SLE)	ICD 10 Code: M32.9
❑ Other:_____	ICD 10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider	❑ Clinical/Progress notes
❑ Patient demographics AND insurance information	❑ Labs and Tests supporting primary diagnosis
❑ Pregnancy Test (if applicable)	❑ ANA (anti-nuclear Ab) and/or anti-dsDNA Test Results

List Tried & Failed Therapies, including duration oftreatment:

1)

2)

MEDICATION ORDERS	
Initial dosing	❑ Benlysta 10 mg/kg IV at Week 0, 2, 4 then every 4 weeks thereafter ❑ Benlysta _____ mg IV at Week 0, 2, 4 then every 4 weeks thereafter
Maintenance Dosing	❑ Benlysta 10mg/kg IV every 4 weeks ❑ Benlysta _____ mg IV every 4 weeks

Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses (all doses including initial loading)

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PREMEDICATIONS
✓ Acetaminophen 1000mg PO, 30-60 minutes prior to Benlysta infusion
✓ Diphenhydramine 25mg IV, 30 minutes prior to Benlysta infusion
✓ Methylprednisolone 80mg IV 30 minutes prior to Benlysta infusion
❑ Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207

All information contained in this form is strictly confidential and will become part of the patient's medical record.