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**BENLYSTA (BELIMUMAB)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis
- ANA Test

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis: Systemic Lupus Erythematosus (ICD-10 Code: _____)

J Code: J0490

BENLYSTA ORDERS

Patient Weight: _____ kg

Benlysta 10mg/kg in 250mL of NS IV over 60 minutes

Frequency: Induction - 0, 14 days, 28 days Every 28 days *Refills _____

Protocol Pre-Medication Orders: Tylenol 650mg PO, *please choose one antihistamine:*

- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Loratadine 10mg PO

Additional Pre-Medication Orders: Solu-Medrol _____ mg IVP
 Solu-Cortef _____ mg IVP

Lab Order: _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	