



DEHESA DERMATOLOGY

Dehesa Dermatology
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<https://dehesadermatology.com>

BELIMUMAB (BENLYSTA) INFUSION ORDER

Patient Information

Patient Name: _____

Address: _____

DOB: _____

Patient Height: _____

Phone: _____

Patient Weight (kg): _____

Diagnosis: _____

ICD-10 Code: _____

Attach:

- ☐ Patient demographics
- ☐ Copy (front & back) of insurance card(s)
- ☐ Most recent clinical notes

Required (Results must accompany order)

- ☐ Tuberculosis Screening (QuantiFERON-TB Gold or TST)
- ☐ Hepatitis B Surface Antigen (HBsAg)
- ☐ Hepatitis B Core Antibody (Total Anti-HBc)
- ☐ Hepatitis C Screening
- ☐ Baseline CBC
- ☐ Baseline CMP

Provider confirms:

- ☐ No active infection
- ☐ Vaccinations reviewed (avoid live vaccines during treatment)
- ☐ No contraindication to belimumab therapy

Medication Order

☐ Belimumab (BENLYSTA®) _____ mg IV

Dosing Regimen

Initial Dosing:

- ☐ 10 mg/kg IV at Week 0, 2 and 4
- ☐ Other: _____

Maintenance Dosing:

- ☐ 10 mg/kg IV every 4 weeks thereafter
☐ Other: _____

Pre-Medications (Administer 30 minutes prior to infusion if indicated)

- ☐ None
☐ Acetaminophen 650 mg PO once
☐ Diphenhydramine 25–50 mg PO or IV once
☐ Methylprednisolone _____ mg IV once
☐ Other (Specify): _____

PRN Administer per infusion reaction protocol if clinically indicated:

- ☐ Diphenhydramine 25–50 mg IV PRN
☐ Methylprednisolone 125 mg IV PRN
☐ Famotidine 20 mg IV PRN
☐ Epinephrine 0.3 mg IM PRN anaphylaxis
☐ Albuterol 2.5 mg nebulized PRN bronchospasm
☐ Normal Saline IV bolus PRN hypotension
☐ Call ordering provider for moderate/severe reaction.

Additional Instructions

Ordering Physician:

Printed Name: _____

Signature: _____ Date: _____ 32 _____

Contact Person: _____

Phone: _____ Fax: _____

FAX ORDER TO 559.234.6334