sage infusion

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(belimumab)

BENLYSTA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Systemic Lupus Erythmatosus

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____
(other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____
(other)

BENLYSTA ORDERS

DOSAGE

◉ _____mg

Notify MD if patient weight changes by _____ lbs. / kg (please circle)

PATIENT WEIGHT

_____lbs.

_____kg

FREQUENCY

○ Dose at weeks 0, 2, and 4, then every 4 weeks

○ Dose every 4 weeks

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____