Belimumab (BENLYSTA)

Weight: ___________ kg  Height: ___________ cm

Allergies: ________________________________________________________________

Diagnosis Code: __________________________________________________________

Treatment Start Date: ___________  Patient to follow up with provider on date: ___________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING

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

LABS:

☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One

PRE-MEDICATIONS: (Administer 15-30 minutes prior to infusion)

*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(s)*

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
   ☐ 650 mg
   ☐ 325 mg
   ☐ 500 mg
   ☐ 1000 mg
2. loratadine (CLARITIN) tablet, oral, ONCE, every visit
   ☐ 10 mg
   ☐ 5 mg

MEDICATIONS: (must check one)

belimumab (BENLYSTA) 10 mg/kg in NaCl 0.9% 250 mL, intravenous, ONCE, over 1 hour
   ☐ Every 2 weeks for 3 treatments (week 0, 2 and 4)
   ☐ Every 4 weeks thereafter (week 8 and beyond)

Pharmacist will use most recent weight and round dose up to the nearest 100 mg

HYPERSENSITIVITY MEDICATIONS:

1. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1
dose for mucosal swelling or edema
2. EPINEPPhrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for
hypersensitivity reaction

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or body aches
2. diphenhydRAMINE (BENADRYL) capsule, 25-50 mg, oral, EVERY 4 HOURS AS NEEDED for rash, itching
NURSING ORDERS:
1. VITAL SIGNS – Vital signs and status at the start of the infusion, every 30 minutes until the end of infusion and when infusion complete.
2. Patient with active infection should not receive Belimumab and should have infusion rescheduled until infection has subsided.
3. Monitor patient for infusion related or hypersensitivity reactions (itching, swelling, difficulty breathing, low blood pressure, anxiousness, headache, nausea, skin rash, etc.)
4. Counsel patients to be aware of hypersensitivity reactions for 2 to 3 hours after first 2 infusions
5. If infusion related event develops or hypersensitivity reactions (Temp > 38.5, chills/rigors, decrease in SBP > 30 mmHg from baseline, mucosal congestion/edema, shortness of breath or cardiac arrhythmia) do the following:
   a. Stop the infusion
   b. Notify physician immediately
   c. If anaphylaxis: Page Rapid Response Team
   d. Treat symptoms as described
   e. Monitor patient status and vital signs until stable
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ ______________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # ______________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ___________________________ Date/Time: ___________________________
Printed Name: ___________________________ Phone: __________________ Fax: ___________________
OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

- **Beaverton**
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

- **NW Portland**
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

- **Gresham**
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

- **Tualatin**
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)