Belimumab (BENLYSTA)
Infusion

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

NURSING ORDERS:
1. Patient with active infection should not receive Belimumab and should have infusion rescheduled until infection has subsided
2. Monitor patient for infusion related or hypersensitivity reactions (itching, swelling, difficulty breathing, low blood pressure, anxiousness, headache, nausea, skin rash, etc.)
3. Counsel patients to be aware of hypersensitivity reactions for 2 to 3 hours after first 2 infusions
4. Vital signs and status at the start of the infusion, every 30 minutes until the end of infusion and when infusion complete.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 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)
☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
   Give either loratadine or diphenhydrAMINE, not both.
☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit.
   Give either loratadine or diphenhydrAMINE, not both.

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)
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

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydramine (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. epinephrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction

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)