Referral Status: ☐ New Patient ☐ Updated Patient Information

# CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

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**If referring provider and/or patient is external to Conway Medical Center. Please include:**

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

# Benlysta® (belimumab) Treatment Plan

**Patient Name:** _____ **Patient DOB** _____/_____/_____

**General**

☐ Diagnosis- Systemic lupus erythematosus, organ or system involvement ICD-10 Code _____
☐ Diagnosis- Glomerular disease in systemic lupus erythematosus ICD-10 Code _____
☐ Diagnosis- Tubulo-interstitial nephropathy in systemic lupus erythematosus ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

**Authorized Treatment Duration**

**Loading Dose**: ☐ Every 2 weeks for 3 doses then every 4 weeks x 12 months
**Maintenance Dose**: ☐ Every 4 weeks x 12 months

**Infusion**

☑ Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp
Baseline on arrival to unit, upon completion of therapy, and prior to discharge

**Pre-Medications**

Tylenol (Day 0, 14, 28)
☐ *650 mg, Oral, Tab, Day of Tx*
*Comments: Administer 30 minutes before belimumab dose*

Benadryl (Day 0, 14, 28)
☐ *25 mg, IV Push, Injection, Day of Tx*
*Comments: Administer 30 minutes before belimumab dose*
☐ *50 mg, IV Push, Injection, Day of Tx*
*Comments: Administer 30 minutes before belimumab dose*

☑ **Benlysta**
*10 mg/kg, IV Piggyback, Powder-Inj, Day of Tx*
*Comments: Dilute in 250 mL 0.9% NaCl and administer as an intravenous infusion over 1 hour. Protect from light (***Pharmacy to round dose per CMC Belimumab roudning table)**

☑ Communication Order
*Patients must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician*

☑ Communication Order
*Obtain results of PPD test or other test to exclude latent tuberculosis if results not present in medical record. Results must be from the last 12 months*

☑ Communication Order
*Confirm patient has not received live vaccine 30 days before or concurrently with belimumab*

**Prescriber Signature (No Stamped Signatures or Electronic Signatures)**

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____

# Benlysta® (belimumab) Treatment Plan

☑ Notify Provider
*for Fever/Chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticarial, persistent flushing, Temperature > 100 or HR <50 or > 130*

☑ Notify Provider
*For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months*

☑ INF Infusion Room Orders Subphase (Day 0, 14, 28)

| If Calculated dose between: (does in mg) | | | Round to: (dose in mg) | Using this vial combination | |
|---|---|---|---|---|---|
| | | | | 120 mg vials | 400 mg vials |
| 120.0 | and | 134.0 | 120 | 1 | 0 |
| 240.0 | and | 268.0 | 240 | 2 | 0 |
| 360.0 | and | 402.0 | 360 | 3 | 0 |
| 402.0 | and | 446.6 | 400 | 0 | 1 |
| 480.0 | and | 536.0 | 480 | 4 | 0 |
| 536.0 | and | 580.6 | 520 | 1 | 1 |
| 600.0 | and | 670.0 | 600 | 5 | 0 |
| 670.0 | and | 714.6 | 640 | 2 | 1 |
| 720.0 | and | 804.00 | 720 | 6 | 0 |
| 804.0 | and | 848.6 | 760 | 3 | 1 |
| 848.6 | and | 893.3 | 800 | 0 | 2 |
| 893.3 | and | 938.0 | 840 | 7 | 0 |
| 938.0 | and | 982.6 | 880 | 4 | 1 |
| 982.6 | and | 1027.3 | 920 | 1 | 2 |
| 1027.3 | and | 1072.0 | 960 | 8 | 0 |
| 1072.0 | and | 1116.6 | 1000 | 5 | 1 |
| 1116.6 | and | 1161.3 | 1040 | 2 | 2 |
| 1161.3 | and | 1205.9 | 1080 | 9 | 0 |
| 1205.9 | and | 1250.6 | 1120 | 6 | 1 |
| 1250.6 | and | 1295.3 | 1160 | 3 | 2 |
| 1295.3 | and | 1339.9 | 1200 | 0 | 3 |

| Continued If Calculated dose between: (does in mg) | | | Round to: (dose in mg) | Using this vial combination | |
|---|---|---|---|---|---|
| | | | | 120 mg vials | 400 mg vials |
| 1339.9 | and | 1384.6 | 1240 | 7 | 1 |
| 1384.6 | and | 1429.3 | 1280 | 4 | 2 |
| 1429.3 | and | 1473.9 | 1320 | 1 | 3 |
| 1473.9 | and | 1518.6 | 1360 | 8 | 1 |
| 1518.6 | and | 1563.3 | 1400 | 5 | 2 |
| 1563.3 | and | 1607.9 | 1440 | 2 | 3 |
| 1607.9 | and | 1652.6 | 1480 | 9 | 1 |
| 1652.6 | and | 1697.3 | 1520 | 6 | 2 |
| 1697.3 | and | 1741.9 | 1560 | 3 | 3 |
| 1741.9 | and | 1786.6 | 1600 | 0 | 4 |
| 1786.6 | and | 1831.1 | 1640 | 7 | 2 |
| 1831.3 | and | 1875.9 | 1680 | 4 | 3 |
| 1875.9 | and | 1920.6 | 1720 | 1 | 4 |
| 1920.6 | and | 1965.3 | 1760 | 8 | 2 |
| 1965.3 | and | 2009.9 | 1800 | 5 | 3 |
| 2009.9 | and | 2054.6 | 1840 | 2 | 4 |
| 2054.6 | and | 2099.2 | 1880 | 9 | 2 |
| 2099.2 | and | 2143.9 | 1920 | 6 | 3 |
| 2143.9 | and | 2188.6 | 1960 | 3 | 4 |
| 2188.6 | and | 2233.2 | 2000 | 0 | 5 |

**Prescriber Signature (No Stamped Signatures or Electronic Signatures)**

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____