Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ______________________________ Patient D.O.B.__________________________

Current Height: ___________________________ Current Weight__________________________

Patient Phone # (______) _______-________________ Gender_______________________

Patient Address ____

City_________________ State _______________ Zip Code_________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (______) _______-________________ Office Contact: ___________________________

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 (Day 0, 14, 28)
every 15 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 15 minutes during the infusion 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 to nearest 50mg)

☑ 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

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)

☐ heparin flush 100 units/mL intravenous solution (Day 0, 14, 28)
5 mL, Intracatheter, Injection, Once, PRN other (see comment)
Comments: To maintain central line patency for implanted ports, flush once monthly or prior to deaccess

Labs Duration: 12 months

☑ QuantiFERON TB Gold Plus (if needed)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ________________________ Provider Name (please print)________________________

Date_____/_____/__________ Patient Name ____________________________ Patient DOB_______________

☐ Biosimilar Substitution **NOT** permitted