Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

BENLYSTA ORDER
(Belimumab)

Please fax a copy of patient's demographics, insurance information, current lab results including TB, H&P relevant to the diagnosis and current medications

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

PRE-MEDICATIONS:	**Benadryl**	☐ **PO**	☐ **IV**	☐ **25mg**	☐ **50mg**	☐ **Pre med**	☐ **PRN**
	Acetaminophen	☐ **PO**		☐ **650mg**		☐ **Pre med**	☐ **PRN**
	Zyrtec	☐ **PO**		☐ **10mg**		☐ **Pre med**	☐ **PRN**
	Solu-Medrol		☐ **IV**	**_____mg**		☐ **Pre med**	☐ **PRN**

Benlysta (Belimumab) IV Dosage:

Dose: _____ (10 mg/kg)

Loading dose: every 2 weeks X 3 doses (days 0, 14, 28)

then every 4 weeks

Start Date of Infusion: _____/_____/_____

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____