Benlysta Order
(Belimumab)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current CBC & CMP ☐ H & P Relevant to the Diagnosis ☐ Current Medications ☐ TB Labs

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS:

Benadryl:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Acetaminophen:	☐ PO		☐ 650mg		☐ Pre-med	☐ PRN
Zyrtec:	☐ PO		☐ 10mg		☐ Pre-med	☐ PRN

BENLYSTA (BELIMUMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

Dose: _____ (10 mg/kg) Start Date of Infusion: _____

Loading Dose: every 2 weeks x 3 doses (days 0, 14, 28) then every 4 weeks

Revised 04/12/22