TOTAL INFUSION
human-centered care

Belimumab
(BENLYSTA)

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: _____

DOB: _____ Phone: _____

Gender: ☐ Male ☐ Female

Allergies: _____

DIAGNOSIS (ICD-10 code required):

☐ _____ Systemic Lupus Erythematosus (SLE)

☐ _____ Other: _____

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Consider anti-nuclear antibody (ANA) and/or anti-double stranded DNA (anti-dsDNA) prior to initial treatment
- Live vaccines should not be given 30 days before or concurrently during treatment
- Not recommended for use in combination with other biologics or IV Cyclophosphamide

TREATMENT CRITERIA:

Hold Belimumab (BENLYSTA) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- Live vaccines received within 30 days of treatment

Notify Provider if:

- Baseline ANA and/or anti -dsDNA have not been drawn prior to initial treatment
- New or worsening neurological symptoms such as memory loss, trouble thinking, dizziness, loss of balance, loss of vision, difficulty talking or walking
- New or worsening symptoms of depression, suicidal thoughts/ behavior, or other mood changes

Nursing Considerations:

- Monitor for adverse reaction, including vital signs and pulse ox, every 30 minutes during infusion and 30 minutes post infusion

Special Instruction(s):

Premedications

☑ **Acetaminophen (TYLENOL) 650mg PO**, Once, 30 minutes prior to Belimumab infusion.

☑ **Cetirizine (ZYRTEC) 10mg PO**, Once, 30 minutes prior to Belimumab infusion.

☐ _____

Medications

Patient Weight _____kg **(REQUIRED)**

Infuse **Belimumab (BENLYSTA)** Intravenously over 60 minutes

Dose:

☑ 10mg/kg

☐ _____

Frequency:

☐ Every 2 weeks x 3 doses, then every 4 weeks

☐ Every 4 weeks

☐ _____

☑ **IV LINE CARE** per Nursing Policy

☑ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

☑ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Provider Signature _____ Date _____ Email _____

Printed Name _____ Phone _____ Fax _____

Office Contact _____ Phone _____ Email _____