UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Benlysta IV Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes**.

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: ________/______/______

Patient Name: ______________________________ DOB: _______/______/______

Allergies: ______________________ Patient Weight: ____________lbs/kg Height: ___________

ICD-10: ______________________, ______________________, ☐ Severe active SLE ☐ Severe active CNS SLE ☐ NA

Copy of Benlysta Gateway Authorization Form attached ☐ Yes ☐ No

Is adequate form of birth control being used? ☐ Yes ☐ No

What is patient SELENA-SLEDAI score prior to starting Benlysta? ______________________

Lupus nephritis: Does patient have active disease with renal biopsy (III-V)? ☐ Yes ☐ No, eGFR <30 ☐ Yes ☐ No

In the past year, what medications for the above diagnosis has the patient tried, failed or is currently taking?

Drug	Dose	Dates of use

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ __________

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:______________

Pre-Medications:			
Diphenhydramine PO or IV	25mg or 50mg	☐ Yes	☐ No
Cetirizine PO	10mg	☐ Yes	☐ No
Acetaminophen PO	650mg	☐ Yes	☐ No
Hydrocortisone IV	________mg	☐ Yes	☐ No

Benlysta (belimumab) IV

☐ **10mg/kg** ☐ **______mg/kg**

Frequency: ☐ **Initial dosing every 2 weeks for 3 doses THEN every 4 weeks** ☐ **q 4 wks**

Printed Provider Name: ______________________________

Provider Signature: ______________________________

Office Phone Number: (   ) ______________________ Office Fax Number: (   ) ______________________

Contact Name: ______________________ Contact Phone Number: (   ) ______________________

New referring providers, how did you hear about us?

☐ Web Search ☐ Pharma Rep ☐ Drug Locator ☐ Patient ☐ Word of Mouth ☐ IA Clinical Liaison ☐ IA Website ☐ Facebook ☐ Instagram ☐ Other: ______________________