Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Benlysta® (belimumab) Infusion Order (Revised 11/5/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ M32.10 - Systemic lupus erythematosus, organ or system involvement	☐ M32.14 - Glomerular disease in systemic lupus erythematosus
☐ M32.15 - Tubulo-interstitial nephropathy in systemic lupus erythematosus	☐ Other:

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold Treatment and Notify Provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required Lab Results: Hep B Profile and PPD/Quantiferon Gold PRIOR to FIRST treatment (**Fax labs with order**)

☑ Notify Provider IF:
- Hep B Panel: POSITIVE or not on file;
- PPD/Quantiferon Gold: POSITIVE or not on file.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Instruct the patient to call the ordering provider's office if patient develops headache, nausea, itching, fatigue, or fever.
☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.
☑ Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 1000mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Ondansetron (Zofran) 4mg IV ONCE
☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy: (Check all appropriate boxes)

☐ LOADING DOSES: Week 0, Week 2, and Week 4
  ☐ Belimumab (Benlysta) 10mg/kg IV over 60 minutes
☐ MAINTENANCE doses: (**Start 4 weeks after the loading doses**)
  ☐ Belimumab (Benlysta) 10mg/kg IV over 60 minutes every 4 weeks

Supportive Care Medications:

☑ Sodium Chloride 0.9% bolus 250mL ONCE PRN headaches.
☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6).
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:
Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: