OHSU Health **Oregon Health & Science University** **Hospital and Clinics Provider's Orders** PO9031 ADULT AMBULATORY INFUSION ORDER **Belimumab (BENLYSTA) Infusion** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.

LABS:

☐ CBC with differential, Routine, ONCE, every_____ (visit)(days)(weeks)(months) – *Circle One*

NURSING ORDERS:

1. Patient with active infection should not receive Belimumab and should have infusion rescheduled until infection has subsided
2. Monitor patient for infusion related or hypersensitivity reactions (itching, swelling, difficulty breathing, low blood pressure, anxiousness, headache, nausea, skin rash, etc.)
3. Counsel patients to be aware of hypersensitivity reactions for 2 to 3 hours after first 2 infusions
4. Vital signs and status at the start of the infusion, every 30 minutes until the end of infusion and when infusion complete.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
Give either loratadine or diphenhydrAMINE, not both.
☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
☐ Other _____

MEDICATIONS: ***(must check one)***

belimumab (BENLYSTA) 10 mg/kg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1 hour
☐ Every 2 weeks for 3 treatments (week 0, 2 and 4)
☐ Every 4 weeks thereafter (week 8 and beyond)

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AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or body aches
2. diphenhydrAMINE (BENADRYL) capsule, 25-50 mg, oral, EVERY 4 HOURS AS NEEDED for rash, itching

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610