PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

OP belimumab (Benlysta) (Paper)

Diagnosis: ☐ Systemic Lupus Erythematous (SLE) **ICD10:** _____
☐ Lupus nephritis

Verification of T SPOT or Quantiferon: TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: _____/_____/_____ Result: _____

Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____

Hepatitis B and C Testing:

Hepatitis B: Date: _____/_____/_____ Result: _____

Hepatitis C: Date: _____/_____/_____ Result: _____

IV Access:

☐ Saline Lock:
- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:
- ☑ Routine PICC Line Care, labs and restoration
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

☑ Acetaminophen (Tylenol) *650 mg, PO, ONCE*
☑ Cetirizine (Zyrtec) *10 mg, PO, ONCE*
☐ methylPREDNISolone *40 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone *125 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone _____ *mg, Soln, IVP, ONCE*

Medication:

☐ belimumab (Benlysta) *10 mg/kg, IVPB, ONCE every 2 weeks for 3 doses, then ONCE every 4 week interval, Infuse over 1 hour*
☐ belimumab (Benlysta) *10 mg/kg, IVPB, ONCE every 4 weeks, Infuse over 1 hour*

Duration: ☐ *6 months* ☐ *1 year*
☐ *Other:* _____

Other: _____

_____

_____

_____

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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
June 2024 (Header updated and removed reference to Policies)