

Updated Order Order Renewal
 Patient Phone: _____

Patient Address: _____ Patient Email: _____
 Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
 Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Systemic lupus erythematosus: _____
 Other: _____ Description: _____

THERAPY ADMINISTRATION & DOSING

Administer belimumab 10 mg/kg x (current weight)
 _____ kg = _____ mg in 250 mL 0.9% sodium chloride over 60 minutes. If patient weighs less than 40kg dilute to 100ml NS.
 Patient will be monitored for 60 minutes post-infusion following the first three treatments and for 30 minutes post-infusion for all subsequent treatments.

FREQUENCY (Choose one)

Induction: Week 0, Week 2, Week 4, then every 4 weeks
 Maintenance: every 4 weeks
 Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

CBC at each dose every: _____
 CMP at each dose every: _____
 LFT at each dose every: _____
 Other: _____

PRE-MEDICATION ORDERS

Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

Hold infusion and notify provider for:

- Abnormal vital signs
- Signs or symptoms of illness or active infection
- Planned/recent surgical procedures.
- Recent live vaccinations
- New/worsening neurological symptoms or mood changes

Document measured weight at each appointment.
 Record vital signs before infusion, then every 30 minutes until patient discharge.
 Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
 Ordering Provider: _____ Provider NPI: _____
 Referring Practice Name: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with steroids and immunosuppressants
Required Labs: ANA, anti-dsDNA, Anti-SM, Anti-RO/SSA, Anti-LA/SSB, CRP, ESR

Provider Name (print) Provider Signature Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.