Outpatient Infusion Center Benlysta/Saphnelo Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender M F

Patient Address: Email: Insurance:

Additional Information Needed

Fax front/back of insurance card	Fax clinical/progress notes	Fax labs
Fax patient demographics	Fax current medication list	Fax TB and Hap B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

M32.10 Systemic Lupus Erythematosus, Organ or System Involvement Unspecified
M32.8 Other Forms of Systemic Lupus Erythematosus
M32.9 Systemic Lupus Erythematosus, Unspecified
Other DX: ______

Clinical Information:

New Therapy Induction | Therapy Change | Therapy Continuation

Patient Weight: ______ lbs/______ kg | Patient Height: ______ in/ ______ cm

Allergies: ______

Therapies Tried and Failed: ______

TB Test: Date: ______ Results: ______ | Hep B Test: Date: ______ Results: ______

Does the patient have venous access? Yes or No | If yes, What type? ______

If no, Initiate IV access

Lab Orders

CBC w/out diff CMP ESR CRP HBsAg HBsAB HBcAB Quantiferon Gold
Referring Provider

Lab Orders to be done by

Infusion Services
Referring Provider

Prescription Information

Benlysta	Inital Dose: 10mg/kg beginning week, week 2 and week 4 Maintenance Dose: 10mg/kg every 4 weeks after week 4	Dose: 300mg Frequency: every 4 weeks
Saphnelo	Maintenance Dose: ______ mg/kg every ______ weeks after week 4	

Misc Orders

______

______

PICC/ Midline/ CAD dressing to be changed every 7 days.

Flushes

10mL NS Flush Syringe PRN
Heparin 500units/5mL Flush Syringe PRN
50ml NS Bag PRN
250ml NS Bag PRN

Standing Orders for Adverse Reactions

Stop infusion and initiate NS bolus
Notify Supervising physician and ordering provider
Solu-Cortef 100mg SUP signs of adverse reaction
Benadryl 25mg SUP for hives or bronchial inflammation

Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
Oxygen 2-5L nasal cannula
Albuterol 2.5mg inhaled PRN for chest tightness
Other: ______

Prescriber Information

Physician Name: ______ Office Contact Name: ______
Contact #: ______ Fax Number: ______
Address: ______ City/State/Zip: ______
NPI#: ______ DEA#: ______ State License #: ______

______ ______

Physician's Signature Date Time