Comanche County Memorial Hospital

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

☐ Saphnelo

☐ Inital Dose: 10mg/kg beginning week, week 2 and week 4 ☐ Dose: 300mg

☐ Maintenance Dose: 10mg/kg every 4 weeks after week 4 ☐ Frequency: every 4 weeks

☐ 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