Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Belimumab (BENLYSTA) Infusion (8/2024) Page 1 of 2

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.
☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE, every visit
☐ Other _____

MEDICATIONS: (*must check one*)
Belimumab (BENLYSTA) 10 mg/kg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1 hour
Pharmacist will round dose to nearest increment of 10mg

☐ Every 2 weeks for 3 treatments (week 0, 2 and 4)
☐ Every 4 weeks thereafter (week 8 and beyond)

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, 50 mg, oral, EVERY 4 HOURS AS NEEDED for rash, Itching

(cont.)

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PHYSICIANS ORDERS
(including Medications)

Belimumab (BENLYSTA) Infusion

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

My NPI 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:**_____