

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Wt(kg): \_\_\_\_\_

Allergies: \_\_\_\_\_ Phone: \_\_\_\_\_

## Benlysta (Tocilizumab) Infusion Orders

### Required Information:

Signed order from prescribing provider  
Patient demographics including insurance information  
Supporting clinical documentation: Visit notes, lab & imaging results  
Last ANA

### Primary Diagnosis:

Systemic Lupus Erythematosus (ICD-10: \_\_\_\_\_)

Other: \_\_\_\_\_ (ICD-10: \_\_\_\_\_)

### BENLYSTA ORDERS

Benlysta 10mg/kg

---OR---

Other: \_\_\_\_\_

Frequency: Induction - days 0, 14, and 28  
Every 28 days

*Administered per manufacturer guidelines*

### PRE-MEDICATIONS

PO Tylenol \_\_\_\_\_ mg

PO Cetirizine \_\_\_\_\_ mg

IV Solu-medrol \_\_\_\_\_ mg

PO Loratadine \_\_\_\_\_ mg

PO IV Diphenhydramine \_\_\_\_\_ mg

PO IV Other: \_\_\_\_\_ mg

### LABS

CBC

ESR

Uric Acid

Frequency:

Every Infusion

CMP

TB Quantiferon Gold

Other: \_\_\_\_\_

Every Other Infusion

CRP

Hep B Core/Surface AG

Other: \_\_\_\_\_

One time only

Other: \_\_\_\_\_

CPL Acct #: \_\_\_\_\_

### ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

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Physician Name:

Phone:

Fax:

Physician Signature:

NPI:

Date: