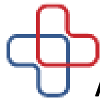 VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion department **Belimumab (BENLYSTA®)** **Certolizumab (CIMZIA®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Weight:________lb/kg Height:______inch/cm
Diagnostic Code ICD-10:________________ Diagnosis:____

□ Initial Consult □ Annual Renewal
Treatment Start Date: _______________

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering. Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P or most recent chart note.
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

MEDICATIONS:
Belimumab (BENLYSTA®) 10 mg/kg = ________ mg in sodium chloride 0.9% 250 mL, intravenous, over 1 hour. Round to the nearest vial size.

- ☐ Every 2 weeks for 3 treatments (week 0, 2 and 4), then every 4 weeks thereafter
- ☐ Every 4 weeks, next dose due:_____________

Certolizumab (CIMZIA®)

- ☐ 400 mg subcutaneously for 3 doses on week 0, 2, 4, then 4 weeks there after
- ☐ 400 mg subcutaneously for every 4 weeks, next dose due:___________
- ☐ 200 mg subcutaneously for every 2 weeks, next dose due:___________

Provider's signature: ____

Provider's printed name: _________________________Date:_______________

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245