Department of Health Care Finance

DC Medicaid Benlysta (belimumab) Patient Education Form

Please initial each statement that you have read and discussed the following information concerning Benlysta (belimumab) with your health care provider (doctor). More detailed patient information is found in the Benlysta Medication Guide available from your pharmacists or other health care provider.

_____I understand that I have been prescribed Benlysta as **add on** therapy to my current therapy for my diagnosis of Lupus or Lupus Nephritis. My doctor has had a discussion of the nature, alternatives, risks and benefits of this medication with me.

_____I understand that by taking Benlysta, I may have an increased risk of infections.

_____ If I experience any possible adverse reactions (side effects) such as fever, chills, pain or burning with urination, urinating often, coughing up mucus, or sores, I will seek medical attention if necessary, and I will notify my doctor as soon as possible.

_____I understand that like with any medication, there may be a risk of an allergic reaction. My health care provider will be monitoring me during treatment. Symptoms of allergic reactions may include itching, swelling of the face, lips, mouth, tongue, or throat, trouble breathing, anxiousness, low blood pressure, dizziness or fainting, headache, nausea, or skin rash.

_____I am NOT taking any Lupkynis (voclosporin), an alternative medication used to treat Lupus

_____I have not had any live vaccinations in the last 30 days and that I am not taking any other biologic medicines or monoclonal antibodies.

_____If I experience new or worsening mental health problems such as trouble sleeping (insomnia), anxiety, depression, or thoughts of suicide I will tell my doctor

For women of childbearing age only

_____If I become pregnant while taking Benlysta, or after stopping Benlysta, I will notify my doctor. If I become pregnant while receiving Benlysta, I will talk to my doctor about enrolling in the Benlysta Pregnancy Registry which conducts enrollment by phone at 1-877-681-6296.

_____*Place a check here if this statement does not apply to you.*

For African American/Black patients only-

_____I have had a discussion with my doctor noting that clinical studies with Benlysta for Lupus have shown limited benefit or have been ineffective compared to standard treatment in African American patients. Alternative treatments may exist for you and these alternatives have been discussed with your doctor

_____*Place a check here if this statement does not apply to you.*

Patient Name:_____Patient Signature: _____ Date:_____

Patient Phone Number:_____ Patient Email:_____

Prescriber Name _____Prescriber Signature:_____ Date: _____

Please fax completed form to the DC Pharmacy Benefit Manager: 866-535-7622.
For any other questions, please call the helpdesk: 800-273-4962