Los Angeles, CA
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INFUSION ORDERS
NULOJIX(BELATACEPTBELATACEPT)

Date: ____________________

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS			
☐New Referral	☐ Dose or Frequency Change	☐ Order Renewal	☐ Discontinuation Order

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

DIAGNOSIS AND ICD 10 CODE	
☐ Kidney Transplant	ICD 10 Code: Z94.0
☐ Other: ______________________________________	ICD 10 Code: ___________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics & insurance information	☐ Labs and Tests supporting primary diagnosis
☐ EBV serology	☐ See attached lab draw protocol
☐ Date of transplant	☐ Please include patient's Nulojix ID number assigned by the Nulojix Distribution Program
☐ See attached infusion dosing protocol	
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS				
Please indicate dose and frequency in blank space as appropriate. If specific dates are requested, please include also. Clinic RNs: please round all weight-baseddoses to nearest 12.5mg.				
Initial Dosing	☐ Nulojix 10mg/kg IV ________________________ ________________________ ☐ Nulojix ______mg IV ______________________ ________________________ _			
Maintenance Dosing ☐ _____ other	☐ Nulojix 5mg/kg IV ___________________________________ ____________ ☐ Nulojix _______ mg IV ________________________________ ____________			
Refills:	☐ X 6 months	☐ X 1 year	☐ _____ doses	☐ _____ total doses
Patient Weight at time of Nulojix initiation: ______________ Clinic RNs: notify referring MD office immediately if the patient's weighton the day of infusiondiffers by 10% from initial weight listed here.				

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

ORDERING PROVIDER

Signature **X** ____ Date ______________

Provider Phone Fax