

INFUSION ORDERS NULOJIX[®] (BELATACEPT)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal	☐ Discontinuation Order
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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-based doses to nearest 12.5mg.

Initial Dosing	☐ Nulojix 10mg/kg IV _____
	☐ Nulojix _____ mg IV _____
Maintenance Dosing	☐ Nulojix 5mg/kg IV _____
☐ _____ other	☐ 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 weight on the day of infusion differs 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