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ThrIVewell™ INFUSION
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Mission Medical

# 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
☐ Patient demographics & insurance information
☐ EBV serology
☐ Date of transplant
☐ See attached infusion dosing protocol

☐ Clinical/Progress notes supporting primary diagnosis
☐ Labs and Tests supporting primary diagnosis
☐ See attached lab draw protocol
☐ Please include patient's Nulojix ID number assigned by the Nulojix Distribution Program

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 _____ _____<br>☐ Nulojix _____mg IV _____ _____ _ |
| Maintenance Dosing<br>☐ _____ other | ☐ Nulojix 5mg/kg IV _____ _____<br>☐ 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