☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Office: 212-803-3339 Fax : 646-768-8600

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

# INFUSION ORDERS
# NULOJIX (BELATACEPT)

**Date:** ____________________

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

**REFERRAL STATUS**

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

**INFUSION OFFICE PREFERENCES (Optional)**

Preferred Location*:

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

| 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 ______________________________<br>Nulojix ______mg IV ______________________________ |
| Maintenance Dosing | Nulojix 5mg/kg IV ______________________________<br>Nulojix _______ mg IV ______________________________ |

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ 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: | | |

## ORDERING PROVIDER

Signature **X** ________________________________________ Date ____________

Provider _______________________ Phone __________ Fax ____________