

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



INFUSION ORDERS NULOJIX (BELATACEPT/BELATACEPT)

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

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics & insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> EBV serology	<input type="checkbox"/> See attached lab draw protocol
<input type="checkbox"/> Date of transplant	<input type="checkbox"/> Please include patient's Nulojix ID number assigned by the Nulojix Distribution Program
<input type="checkbox"/> 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	<input type="checkbox"/> Nulojix 10mg/kg IV _____	<input type="checkbox"/> Nulojix _____ mg IV _____
Maintenance Dosing <input type="checkbox"/> _____ other	<input type="checkbox"/> Nulojix 5mg/kg IV _____	<input type="checkbox"/> Nulojix _____ mg IV _____
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses <input type="checkbox"/> _____ 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