☐ *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

☐ *NYC Central Park West*
115 Central Park West
Suite 15
New York, NY 10023

☐ *Woodbury*
75 Froehlich Farm
Woodbury, NY 11797

☐ *Staten Island*
27 New Dorp Lane
Staten Island, NY 10306

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

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

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

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

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

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

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

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Bronx*
226 West 238th Street
Bronx, NY 10463

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 _____ _____ ☐ 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