Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

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

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 _____ _____ ☐ 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