

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053



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

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

INFUSION ORDERS NULOJIX[®] (BELATACEPT)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal	☐ Discontinuation Order
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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
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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 _____ ☐ 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 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 _____