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

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY, 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

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

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

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

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 _____