

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

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-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