Nulojix Order Form
(belatacept)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ Z94.0 Kidney Transplant Status

Other: _____

Prescribing Information

Nulojix is contraindicated in transplant recipients who are Epstein-Barr (EBV) seronegative or have an unknown serostatus.

Patient **MUST** be enrolled in the Nulojix Distribution Program (NDP) and have a patient ID number from NDP. Medication **cannot** be ordered for new or existing patients without ID number. Call Bristol-Myers Squibb at 855.511.6180 to enroll.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include Negative TB and Epstein-Barr serology.**

PRESCRIPTION

Lab Orders[+]

Required: Negative TB, annually

[+]**Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.**

Nulojix Distribution Program Patient ID #: _____ **(REQUIRED FOR MEDICATION TO BE ORDERED)**

Date of Patient's Last Dose of Nulojix: _____

Transplant Date: _____

Weight at Transplant: _____ lbs **or** _____ kg

Patient Current Weight: _____ lbs **or** _____ kg

[+]Dose is calculated on transplant weight unless weight varies by > 10%

Nulojix (belatacept)

Dose:

IV: Infuse 5 mg/kg in 100 mL of 0.9% Sodium Chloride over a minimum of 30 minutes via pump using a 0.2-micron filter, every 4 weeks **Duration:** _____

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature***: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____