Nulojix Order Form
(belatacept)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

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 exisiting 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

Nulojix Distribution Program Patient ID #: _____
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%**

Lab Orders+
Required: Negative TB, anually

+Medix Infusion will draw required CBC/BMP if not supplied by Referring Provider

NULOJIX (belatacept)

Loading Dose

IV: Infuse 5 mg/kg in 100 mL of 0.19% Sodium Chloride over a minimum of 30 minutes via pump using a 0.2-micron filter, every 4 weeks

Duration: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

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

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

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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