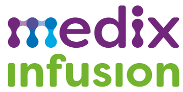

Nulojix Order Form
(belatacept)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______________ Phone: ______________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)
Z94.0 Kidney Transplant
Other: ______________________________

* Dose is calculated on patient weight at time of transplant unless weight varies ≥ 10%.
If weight differs > 10%, contact provider.

Patient Status:
New to therapy
Continuing therapy (date of last dose ______________)

Nulojix Distribution Program Patient ID #: ______________

Transplant Date: ______________________________
Patient weight at time of transplant: __________ lb kg
Patient weight (current): __________ lb kg

Height: ______________________________

Allergies: ______________________________

Date of Patient's Last Dose of Nulojix: ______________
Patient has received __________ doses thus far.
Next dose due on ______________

PRESCRIPTION

NULOJIX (belatacept)

Initial Phase Dosing and Maintenance:
10 mg/kg IV on day 1 (day of transplantation, prior to transplantation), day 5, at the end of week 2, end of week 4, end of week 8, and end of week 12 after transplantation. Then, 5 mg/kg IV at the end of week 16 after transplantation and every 4 weeks (plus or minus 3 days) thereafter for one year.

Maintenance Dose Only:
5 mg/kg IV every 4 weeks for one year

Is the patient on any other disease modifying therapy? Yes No

Is yes, please note therapy and last dose: ______________________________

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

Other Orders:

____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Lab Results: Negative TB within 12 months of initiating therapy and positive Epstein-Barr serology prior to initiating therapy

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

Signature: ______________________________

NPI #: ______________________ Date: ______________

Supervising Physician (if applicable): ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Contact Name: ______________ Phone: __________ Fax: __________