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New Rochelle, NY
1080

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INFUSION ORDERS NULOJIX (BELATACEPT) Date: _____

_____ ok the switch to biosimilar if insurance formulary prefers

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Kidney Transplant	ICD 10 Code: Z94.0
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics & insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> EBV serology	<input type="checkbox"/> See attached lab draw protocol
<input type="checkbox"/> Date of transplant	<input type="checkbox"/> Please include patient's Nulojix ID number assigned by the Nulojix Distribution Program
<input type="checkbox"/> See attached infusion dosing protocol	

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	Nulojix 5mg/kg IV _____ Nulojix _____ mg IV _____

Refills: X 6 months X 1 year _____ 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:		

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____