Nulojix
(belatacept)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Kidney transplant status (Z94.0)

☐ Encounter for aftercare following kidney transplant (Z48.22)

☐ Other: _____

PRESCRIPTION

☐ **Initial Phase:** Nulojix _____ mg (10mg/kg) IV on Day 1 (day of transplantation, prior to implantation), Day 5, at the end of Week 2, Week 4, Week 8, and Week 12 after transplantation. Then _____ mg (5mg/kg) at the end of week 16 after transplantation and every 4 weeks (+/- 3 days) thereafter.

*Patient has received _____ doses thus far, next dose due on: _____

☐ **Maintenance:** Nulojix 5mg/kg IV every 4 weeks

☐ Other: _____

Calculated dose will become fixed dose throughout treatment, based on actual body weight at time of transplant unless there is a change in body weight of greater than 10%

Patient weight at time of transplant: _____ kg

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most recent labs
- Medication List
- Negative TB results
- Positive Epstein-Barr (EBV) serology

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.