LIFE SPECIALTY SOLUTIONS

NULOJIX
(belatacept)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. Neg TB Results 7. Positive Epstein-Barr (EBV) serology

PRIMARY DIAGNOSIS

☐ Z94.0 Kidney transplant status ☐ Z48.22 Encounter for aftercare following kidney transplant

☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

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

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Nulojix

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Induction: Nulojix 10mg/kg (_____mg) IV on days 1, 5, 14, 28, then every 4 weeks x2 doses

☐ Maintenance: Nulojix 5mg/kg (_____mg) IV every 4 weeks

☐ Other: _____

***Calculated dose will become fixed dose throughout treatment, based on actual body weight at time of transplant unless otherwise specified

***Patient weight at time of transplant:_____kg

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

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

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE