Nulojix

INFUSION FOR HEALTH

Treatment Location: ____________

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ Z94.0 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

☑ TB Status and Date (list results & attach clinicals): ____________

☑ EBV Status and Date (list results & attached clinicals) ____________

NULOJIX is contraindicated in patients who are EBV seronegative or with unknown serostatus.

☑ Date of Transplant: ____________

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: ____________

Dose: ________ Route: ________ Frequency: ________

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ________

☐ CMP ☐ at each dose ☐ every ________

☐ Other: ________ ☐ Frequency: ________

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Nulojix Intravenous Infusion

☐ **Loading Dose:**
10 mg/kg x ______ kg= ______ mg (must be divisible by 12.5mg)
Frequency:
Day 1 (day of transplantation, prior to implantation), Day 5 End of Week 2, Week 4, Week 8, and Week 12 after transplantation
*Please indicate if patient has received any previous infusions

☐ **Maintenance Dose:**
5 mg/kg x ______ kg = ______ mg (must be divisible by 12.5mg)
Frequency: End of Week 16 after transplantation and every 4 Weeks (+/-3 days) thereafter

☐ **Other Dose:** ____________

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ____________
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite “Brand Medically Necessary” on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) ____________ Provider Signature ____________ Date ____________

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***