Nulojix
(Belatacept)

INFUSION FOR HEALTH

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; TB lab results, EBV lab results

PATIENT INFORMATION

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

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

- ☑ Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- ☑ TB Status and Date (list results & attach clinicals): _____
- ☑ EBV lab results (EBV VCA Antibody-IgG and EBV Nuclear Antigen Antibody) *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
- ☐ **Initial Phase:**
  Any order for initial phase is considered "off-label" and requires explicit instructions including dose and frequency:

- ☐ **Maintenance Phase:**
  Dose: 5mg/kg (dose given will be divisible by 12.5mg)
  Frequency: every 4 weeks (+/-3 days) thereafter
- ☑ 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.***