

# Belatacept (Nulojix)

Provider Order Form rev. 01/02/2024

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Allergies: \_\_\_\_\_  NKDA Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_

Sex:  M /  F Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

## DIAGNOSIS (Please provide ICD-10 code in space provided)

Post-renal transplant AND EBV: \_\_\_\_\_

Other: \_\_\_\_\_ Description: \_\_\_\_\_

## THERAPY ADMINISTRATION & DOSING

Administer IV Nulojix \_\_\_\_\_ mg/kg x \_\_\_\_\_ kg = \_\_\_\_\_ mg (will be rounded to nearest 12.5 mg) in 100 mL

0.9% sodium chloride over a period of 30 minutes

For doses exceeding 1000 mg, dilute in 250 ml 0.9% sodium chloride.

## FREQUENCY (Choose one)

Every 4 weeks (+/- 3 days)

Every \_\_\_\_\_ weeks

## ADDITIONAL ORDERS

## PRE-MEDICATION ORDERS

Tylenol  500mg /  650mg PO

Loratadine 10mg PO

Pepcid 20mg  PO /  IVP

Benadryl  25mg /  50mg  PO /  IVP

Solumedrol  40mg /  125mg IVP

Other: \_\_\_\_\_

## NURSING

Hold infusion and notify provider for:

- Signs or symptoms of illness or active infection or Recent live vaccinations
- New or worsening neurological, cognitive, or behavioral signs/symptoms

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

Preferred Contact Name: \_\_\_\_\_ Preferred Contact Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, transplant status

**Required Labs:** Kidney function, CBC, CRP/ESR

\_\_\_\_\_  
Provider Name (print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.