NULOJIX®

Please Fax Completed Form To: 888-340-3699

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: □ M □ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code:_____ Secondary ICD-10 Code:_____ Tertiary ICD-10 Code:_____

Transplant Date: _____-_____-_____ Epstein-Barr Virus (EBV): □ Seropositive □ Seronegative or unknown (contra-indicated)

Will Nulojix be used with basiliximab induction, mycophenolate mofetil, and corticosteroids? □ Yes □ No

Is patient not able to tolerate cyclosporine or tacrolimus due to allergy or intolerance? □ Yes □ No

NULOJIX® ORDERS

Prescription type: □ New start □ Restart □ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
□ Nulojix® (belatacept) initial dosing □ Nulojix® (belatacept) maintenance dosing	□ 10 mg/kg to nearest 12.5 mg increment IV over 30 minutes on day 1 before transplantation, on day 5 approximately 96 hours after the first dose, and at the end of weeks 2, 4, 8, and 12. □ 5 mg/kg to nearest 12.5 mg-increment IV over 30 minutes at the end of week 16 and every 4 weeks +/- 3 days thereafter □ Other: _____	Refills: _____

Pre-Medication	Dose/Strength	Directions
□ Acetaminophen	□ 500mg □ 25mg IV/PO	□ Take 1-2 tablets PO prior to infusion or post-infusion as directed
□ Diphenhydramine	□ 50mg IV/PO □ 40mg □ 100mg	□ Take 1 tablet PO prior to infusion or as directed OR □ Inject contents of 1 vial IV prior to infusion or as directed
□ Methylprednisolone	□ 125mg _____	□ Inject contents of 1 vial IV prior to infusion or as directed □ Other: Inject 100mg IV 30 minutes prior to infusion
□ _____		

INFUSION REACTION ORDERS

Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

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If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline: ☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:** ☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline: ☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	**PICC:** ☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:** ☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

SIGNATURE

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.