



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)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____ Tertiary ICD-10 Code: _____
Transplant Date: _____ - _____ - _____ Epstein-Barr Virus (EBV): <input type="checkbox"/> Seropositive <input type="checkbox"/> Seronegative or unknown (contra-indicated)
Will Nulojix be used with basiliximab induction, mycophenolate mofetil, and corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient not able to tolerate cyclosporine or tacrolimus due to allergy or intolerance? <input type="checkbox"/> Yes <input type="checkbox"/> No

**NULOJIX® ORDERS**

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

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Nulojix® (belatacept) initial dosing <input type="checkbox"/> Nulojix® (belatacept) maintenance dosing	<input type="checkbox"/> 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. <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	Refills: _____

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

**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 mid-antrolateral 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 being 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 \_\_\_\_\_  
Prescriber Signature

Date: \_\_\_\_\_

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.

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