NULOJIX
(belatacept)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Neg TB Results • REMS Pat #_____________________________ • Positive Epstein-Barr (EBV) serology

PRIMARY DIAGNOSIS

☐ Z94.0 Kidney transplant status

☐ Z48.22 Encounter for aftercare following kidney transplant Other:

☐ ____

ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ____________________________________

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Nulojix

☐ Provider Prescribed: ____________________________________

PRIMARY MEDICATION ORDER

☐ Induction: Nulojix 10mg/kg (fixed dose_________mg) IV on days 1, 4, 14, then monthly x3 doses

☐ Maintenance: Nulojix 5mg/kg (fixed dose_________mg) IV monthly

***Calculated dose will become fixed dose throughout treatment, based on actual body weight at time of transplant unless otherwise specified

***Patient weight at time of transplant:_____________kg

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:____________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_______________________________________ Provider Signature

_____________________ Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

REVISED 08/23