FLOMED INFUSION

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NULOJIX (belatacept)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____

Required Labs: EBV serostatus and TB screening

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: _____
- Nolojix Distribution Program Notified (855) 511-6180 - Patient ID _____

NULOJIX (belatacept) ORDERS

Dosing for Initial Phase and Initial Maintenance

☐ _____ mg IV on Day 1 (day of transplantation, prior to transplantation) and Day 5 (approx. 96 hours after Day 1 dose), at the end of week 2, week 4, week 8, and week 12 after transplantation. Then _____ mg IV at the end of week 16 after transplantation and every 4 weeks (plus or minus 3 days) thereafter.

* Patient has received _____ doses thus far, next dose due on _____

Dosing for Maintenance Phase

☐ _____ mg IV every 4 weeks

* Prescribed dose must be evenly divisible by 12.5mg
* The total infusion dose of Nulojix should be based on the actual body weight of the patient at the time of transplantation, and should not be modified during the course of therapy, unless there is a change in the body weight of greater than 10%. If the patient has had >10% weight change, please notify the physician for dose change recommendations.

Additional Orders/Comments: _____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____