NULOJIX(belatacept)

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills: ☐

Rx:

Patient Name: **Patient Weight:** kg **DOB:**

NULOJIX:

☐ Initial Phase: 10mg/kg for 30 mins via IV Infusion
☐ Maintenance Phase: 5mg/kg for 30 mins via IV Infusion every 4 weeks (+/-3 days)

Other Orders:

Pre-Medication: (30 mins prior)

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:
☐ OK to use

Dx:

☐ Kidney Transplant (Z94.0)

☐ OTHERS: (ICD 10 Code: _____)

N P I #:

Physician Signature **Date: (Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **CLINIC:**

Contact Information: **Phone:** **Email:**
Fax: **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis (supporting) ☐ History and Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication List ☐ Other Test Results

☐ EBV Seropositive ☐ TB screening test completed within 12 months

***If TB results are positive - please provide documentation of treatment or medical clearance and a negative CXR**