*Patient Insurance & ID (front and back) are needed

# 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: _____ )

**Physician Signature**

**NPI#:**

**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**