

Nulojix™ (belatacept) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Documentation to support primary diagnosis (Clinical/progress notes, labs, diagnostic tests, etc.)

Patient Name

DOB

Height

Weight

Allergies

Patient Phone

Primary Diagnosis (must include ICD-10 code)

- Kidney transplant _____ (date of transplant : _____)
 EBV sero positive _____ ****REQUIRED****

Prescription Orders: Nulojix™ (belatacept)
****0.2 micron filter must be used during infusion****

_____ mg/kg in 100 mL of normal saline IV over 30 minutes. Give on day 1, day 15, day 29, day 43, day 57. Then _____ mg/kg every 4 weeks.

_____ mg/kg in 100mL normal saline IV over 30 minutes every _____ weeks.

Acetaminophen 650mg PO Benadryl 50 mg PO for infusion reaction.

Labs: _____

Refill for 12 months.

Provider Name

Phone

Fax

Provider signature

Date

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com**