NULOJIX®(BELATACEPT) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** _____ ☐ inches ☐ cm	**Actual Body Weight at Time of Transplantation:** _____ ☐ lbs ☐ kg **Current Weight:** _____ ☐ lbs ☐ kg **Date:**_____

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies: ☐ NKDA OR (List):	
Is this the first dose? ☐ Yes – date of first dose: _____ ☐ No – date of last dose: _____	

Nulojix® (belatacept) Prescription

Nulojix® (belatacept) refill as directed x 1 year

IV Regimen: ☐ Induction Phase Dose: 10mg per kg IV infused over 30 minutes on _____ and then _____.

☐ Maintenance Phase Dose: 5mg per kg IV infused over 30 minutes every 4 weeks beginning _____.

☐ Other: _____

Dose will be rounded to the nearest 12.5mg increment. Will be administered by a healthcare professional.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage: ☐ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.

☐ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.

☐ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Methylprednisolone Sodium Succinate 40 mg IV push 20 minutes prior to infusion.

☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
  For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other:

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

