

NULOJIX® (BELATACEPT) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	Height: _____ <input type="checkbox"/> inches <input type="checkbox"/> cm	Actual Body Weight at Time of Transplantation: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Current Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Date: _____
Clinical Information		
Primary Diagnosis Description:	ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA OR (List):		
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: _____ <input type="checkbox"/> No – date of last dose: _____		
Nulojix® (belatacept) Prescription		
Nulojix® (belatacept) refill as directed x 1 year		
IV Regimen: <input type="checkbox"/> Induction Phase Dose: 10mg per kg IV infused over 30 minutes on _____ and then _____. <input type="checkbox"/> Maintenance Phase Dose: 5mg per kg IV infused over 30 minutes every 4 weeks beginning _____. <input type="checkbox"/> 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 1 st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dosage: <input type="checkbox"/> 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. <input type="checkbox"/> Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (\leq 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement. <input type="checkbox"/> 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (\leq 30 kg) IV at KVO rate PRN anaphylaxis.		
Medication Orders <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> Methylprednisolone Sodium Succinate 40 mg IV push 20 minutes prior to infusion. <input type="checkbox"/> Other: _____		
IV Flush Orders <ul style="list-style-type: none"> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <u>Implanted Port:</u> 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
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		
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