NULOJIX
(belatacept)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Neg TB Results
- Positive Epstein-Barr (EBV) serology

PRIMARY DIAGNOSIS

☐ Z94.0 Kidney transplant status
☐ Z48.22 Encounter for aftercare following kidney transplant
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Nulojix
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Induction: Nulojix 10mg/kg (_____mg) IV on Days 1, 5, 14, 28, then every 4 weeks x2 doses
☐ Maintenance: Nulojix 5mg/kg (_____mg) IV every 4 weeks
☐ Other: _____

***Calculated dose will become fixed dose throughout treatment, based on actual body weight at time of transplant unless otherwise specified
***Patient weight at time of transplant:_____kg

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ Provider Signature

_____ Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals