

## NULOJIX (BELATACEPT) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 Patient has known difficult venous access. Comments: \_\_\_\_\_  
 New Start Therapy |  Continuation of Therapy & Date of last dose (if applicable): \_\_\_\_\_

### DIAGNOSIS (Provider must specify)

Kidney transplant status, ICD 10: Z94.0  
 Other: \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

Demographics  Labs and tests supporting diagnosis  Office/progress notes

### PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO  Famotidine 20 mg IV  Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO  Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

| MEDICATION | DOSE     | ROUTE | FREQUENCY  |
|------------|----------|-------|--|
| Nulojix    | _____ mg | IV    | <input type="checkbox"/> Every 4 weeks<br><input type="checkbox"/> _____ |

### LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

CT: 203.433.0621  
 FL: 904.877.9270

MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

SC: 864.973.6279  
 VA: 703.202.0499