NULOJIX® Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Kidney Transplant

_____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis -Transplant summary note, Transplant Weight: _____ lbs, Epstein-Barr Virus (EBV) Serology Results, TB Screening Results 2. Medication list (including immuno-suppressant regimen) 3. Copy of the patient's Insurance Card 4. Nulojix Distribution Program (NDP) ID#:_____

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **NULOJIX® (belatacept)**

☐ ***New Start:***

Administer Nulojix 10 mg/kg IV* (_____ mg*) on the end of Week 2, Week 4, Week 8 and Week 12.

_____# Doses Authorized to begin the cycle on the end of Week _____ (Date:_____)

☐ ***Maintenance Dose:***

Administer Nulojix 5 mg/kg IV* (_____ mg*) every four weeks

_____# Refills (Recommend 5 Refills) with next scheduled dose due: _____

*Dosing should be in increments of 12.5 mg and dosing weight should be transplant weight, unless there is a change of greater than 10%

Pre-Medication Orders: _____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date