Infusion ASSOCIATES

Phone: 833-394-0600 Fax: 833-996-4888

Nulojix IV Maintenance Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Nulojix distribution program PIN # _____Allergies: _____

Height:_____ Weight (kg) at 1st dose:_____ Current weight (kg):_____

ICD-10 : _____, _____, _____

Date of kidney transplant:_____

Is the patient Epstein-Barr virus seropositive? ☐ No ☐ Yes

Will Nulojix be used with basiliximab induction, mycophenolate mofetil, and corticosteroids? ☐ No ☐ Yes

Is patient not able to tolerate cyclosporine or tacrolimus due to allergy or intolerance? ☐ No ☐ Yes

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Every_____infusion

Nulojix (belatacept) IV

Dose based on actual body weight of patient at time of transplant, dose will be modified if there is a change in body weight of greater than 10%
Doses rounded to nearest 12.5 mg

5mg/kg

Frequency: q 4wks (+/- 3 days)

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____

Contact Name: _____Contact Phone Number: _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____