NULOJIX® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

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 Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date