

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_  
**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**  
 Primary Diagnosis: \_\_\_\_\_ Kidney Transplant ICD-10 Code: Z94.0 \_\_\_\_\_  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Transplant summary note
  - Transplant Weight: \_\_\_\_\_ lbs
  - Epstein-Barr Virus (EBV) Serology Results
  - TB Screening Results
- Medication list (including immunosuppressant regimen)
- Nulojix Distribution Program (NDP) ID#: \_\_\_\_\_

<b>Patient</b> <b>Weight:</b> _____ lbs. <b>Height:</b> _____ in.
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**NULOJIX® (belatacept)** J Code: J0485

**4. Drug Order:**

**Initial Dose:**

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 this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

Dispense as written Substitution permitted

Printed Physician's Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b> <b>ALTERNATE FAX 803.999.1887</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 800.767.6337</b>
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