INTRAMED Plus
infusion services

NULOJIX®

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#:______________

Patient
Weight: __________ lbs.
Height:___________ in.

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 #: ____________________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	**INFUSION CENTER LOCATIONS** COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960

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