HONORHEALTH®

BELATACEPT
(Nulojix)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change	
Diagnosis	☐ Kidney transplant (rejection prophylaxis)	☐ Other: ______________________________		**Diagnosis Code:** ____________

Required Information (please include labs attached)	***Allergies:***		
	Negative QuantiFERON TB or T-spot or chest x-ray	Date:	Weight: __________ (At time of Nulojix initiation)
	EBV serostatus positive	Date:	
	Diagnostic Hepatitis B panel	Date:	
	Coccidioides Screen/Panel	Date:	Height: __________
	CBC, CMP (please include lab result documents)	Date:	

Labs	☐ CMP every ____________		☐ Other:		
Pre-Medications	☐ Diphenhydramine	☐ 25mg	☐ 50mg	☐ IV	☐ PO
	☐ Acetaminophen	☐ 325mg	☐ 650mg		☐ PO
	☐ Other:				

Nulojix (belatacept) IV (Dose based on actual body weight at time of transplantation and should not be modified unless change >10%)	☐ Initial phase: 10mg/kg on day 1, day 5 and followed by 10mg/kg at end of week 2, week 4, week 8 and week 12 following transplantation	*Patient has received ____ doses thus far, next dose due on _______
		☐ Maintenance: 5mg/kg every 4 weeks
		☐ Other:

Infusion Reaction Medications	Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: