Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Nulojix® (belatacept) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ Z94.0 - Kidney Transplant Status

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent H&P and Medication list	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Tried and failed therapies		NEXT INFUSION DATE:
4	Documentation of Epstein-Barr serology		**IF ORDER CHANGE:**
5	Lab results, transplant summary note, and/or tests to support diagnosis.		☐ **Continue current order until insurance approved**
6	**REQUIRED:** TB results for new start patients		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive belatacept if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

NULOJIX® (belatacept) is contraindicated in transplant recipients who are Epstein-Barr (EBV) seronegative or unknown serostatus.

DOSE/FREQUENCY:

☐ Maintenance: Nulojix® (belatacept) 5mg/kg in 100 ml NS IV to infuse over a minimum of 30 minutes every 4 weeks with 0.22 micron filter, **using a silicone free syringe for reconstitution and preparation**

☐ Other: _____

Required for weight based dosing: Transplant date:_____ Patient Transplant weight: _____

(Dose is calculated on transplant weight unless weight varies by > 10%, after which they will be dosed on actual body weight)

SPECIAL/LAB ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	