



Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

NULOJIX MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis

☐ Z48.22 Status post kidney transplant ☐ _____ Other: _____

■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

- When was patient's kidney transplant? _____
- Is Nulojix to be used in combination with any of the following: basiliximab induction, mycophenolate mofetil, and corticosteroids? _____ *If yes, please circle which meds.*
- Provide documentation that patient is Epstein-Barr virus seropositive.
- *Please note that Nulojix for liver transplant, systemic lupus erythematosus, rheumatoid arthritis, psoriatic arthritis, abdominal wall transplant, pancreas transplant, and type 1 diabetes are likely to be considered investigational and not approved by insurance.*

■ Nulojix (belatacept) Medication Order

Select one or both doses required:

- ☐ Initial phase of 10mg/kg on days 1 and 5, and end of weeks 2, 4, 8 and 12.
- ☐ Maintenance phase of 5mg/kg on end of week 16 post transplantation and every 4 weeks +/- 3 days) for _____ months.

*Nulojix is administered in 100ml of normal saline by IV over about 30 minutes using 0.2*1.2 micron IV filter tubing. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.*

■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including Diphenhydramine, Methylprednisolone, Albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.