Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Nulojix [Belatacept]

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ______________________ DOB: __________

NKDA ☐ Allergies: ______________________ Weight ________ *Please specify:* ☐ lbs ☐ kg Height: ________

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): ______________ ICD-10 description: ______________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ TB status & date (list results here & attach clinicals)

____

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ______________________
Dose: ______________ Route: ______________
Frequency: ______________________

* NULOJIX is contraindicated in transplant recipients who are Epstein-Barr virus (EBV) seronegative or with unknown EBV serostatus due to the risk of post-transplant lymphoproliferative disorder (PTLD), predominantly involving the central nervous system (CNS).

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ______________
☐ CMP ☐ at each dose ☐ every ______________
☐ CRP ☐ at each dose ☐ every ______________
☐ Other: ______________________

THERAPY ADMINISTRATION

☐ **Belatacept** (Nulojix) in 0.9% sodium chloride, intravenous infusion, administer with 0.2-1.2 micron filter

- ☐ 10mg/kg Day 1, Day 5, end of week 2, 4, 8 and 12 (Please indicate if patient has received any previous infusions)
- ☐ 5mg/kg end of week 16 and every 4 weeks thereafter
- Prescribed doses must be evenly divisible by 12.5mg
- Final concentration should range from 2mg/ml to 10mg/ml
- Administer over 30 minutes
- ☐ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 30-min observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______________
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: ______________ Referral Coordinator Email: ______________
Ordering Provider: ______________ Provider NPI: ______________
Referring Practice Name: ______________ Phone: ______________ Fax: ______________
Practice Address: ______________ City: ______________ State: ______ Zip Code: ______

______________ ______________ ______________
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK