NULOJIX®(BELATACEPT) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**
Address:	
Phone:	**Height:** _____ ☐ inches ☐ cm **Weight:** _____ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?

☐ Yes – date of first dose: _____

☐ No – date of next dose due: _____

Nulojix® (belatacept) Prescription

Nulojix® (belatacept) refill as directed x 1 year

IV Regimen: ☐ Induction Phase Dose: 10mg per kg IV infused over 30 minutes on _____ and then _____.

☐ Maintenance Phase Dose: 5mg per kg IV infused over 30 minutes every 4 weeks beginning _____.

☐ Other: _____

Dose will be rounded to the nearest 12.5mg increment. Will be administered by a healthcare professional.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage: ☐ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.

☐ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.

☐ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Methylprednisolone Sodium Succinate 40 mg IV push 20 minutes prior to infusion.

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other:

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

