

NULOJIX® (BELATACEPT) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Address:

Phone:

Height: _____ inches cmWeight: _____ 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 NoDosage: 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:

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