INTRAMED Plus
infusion services

NULOJIX®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Kidney Transplant ICD-10 Code: Z94.0_____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Transplant summary note
  - Transplant Weight: _____ lbs
  - Epstein-Barr Virus (EBV) Serology Results
  - TB Screening Results
- Medication list (including immunosuppressant regimen)
- Nulojix Distribution Program (NDP) ID#:_____

Patient
Weight: _____ lbs.
Height:_____ in.

NULOJIX® (belatacept) J Code: J0485

4. Drug Order:

❑ **Initial Dose:**

Administer Nulojix 10 mg/kg IV* (_____ mg*) on the end of Week 2, Week 4, Week 8 and Week 12.
_____# Doses Authorized to begin the cycle on the end of Week _____ (Date:_____)

❑ **Maintenance Dose:**

Administer Nulojix 5 mg/kg IV* (_____ mg*) every four weeks
_____# Refills (ecommend 5 Refills) with n xt scheduled dose due: _____

*Dosing should be in increments of 12.5 mg and dosing weight should be transplant weight, unless there is a change of greater than 10%

Pre-Medication Orders: _____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**