

# NULOJIX® (belatacept)

## Patient Information

Full Name: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Allergies:  NKDA \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Patient Status:  New to therapy  Continuing therapy Last Treatment Date: \_\_\_\_\_ Next Treatment Date: \_\_\_\_\_

## Required Documentation

- Patient Demographics and Insurance Card  Medication List  TB Test  
 Clinical/Progress Notes Supporting Dx  EBV serostatus (attach results)  Date of transplant  
 Patients Nulojix ID number assigned by the Nulojix Distribution Program (855) 511-6180


## Primary Diagnosis

 ICD-10 Code (required): \_\_\_\_\_  
 Kidney Transplant Status  Other: \_\_\_\_\_

## Pre-Medication

- Per violet health protocol: No recommended standard pre-medications for belatacept  
 Acetaminophen (Tylenol) PO  500mg  650mg  1000mg  
 Diphenhydramine (Benadryl)  25mg  50mg  PO  IV  
 Methylprednisolone (Solu-Medrol) IV  40mg  125mg  
 Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_

## Therapy Administration

- Induction: Nulojix 10mg/kg IV on days 1, 5, 14, 28, then every 2 weeks x 2 doses  
 Maintenance: Nulojix 5mg/kg IV every 4 weeks  
 Other: \_\_\_\_\_  
 Calculated dose will become fixed dose throughout treatment, based on actual body weight at time of transplant unless otherwise specified  
**Refills:**  
 x 1 year  Other: \_\_\_\_\_  
 RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)  
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)  
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.  
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.  
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

## Lab Orders

- CBC  at each dose  every \_\_\_\_\_  CRP  at each dose  every \_\_\_\_\_  
 CMP  at each dose  every \_\_\_\_\_  Other: \_\_\_\_\_

## Provider Information

Provider Name: \_\_\_\_\_ Office Contact Person: \_\_\_\_\_  
 Referring Practice Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Referring Practice Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_