NORTH TEXAS INFUSION CENTERS

Nulojix™ (belatacept) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Documentation to support primary diagnosis (Clinical/progress notes, labs, diagnostic tests, etc.)

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Primary Diagnosis (must include ICD-10 code)
☐ Kidney transplant _____ (date of transplant :_____)
☐ EBV sero positive _____ ☐ other diagnosis:_____

Prescription Orders: Nulojix™ (belatacept)
0.2 micron filter must be used during infusion

☐ _____mg/kg in 100 mL of normal saline IV over 30 minutes. Give on day 1, day 5, week 2, week 4, week 8, and week 12. Then _____ mg/kg every 4 weeks.

☐ _____mg/kg in 100mL normal saline IV over 30 minutes every ____ weeks.

☐ Acetaminophen 650mg PO ☐ Benadryl 50 mg PO for infusion reaction.

☐ **Labs:**_____

☐ **Refill for 12 months.**

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com