Belatacept (Nulojix)

Provider Order Form rev. 9/30/2021

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

☑ TB status and date (results) _____

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

THERAPY ADMINISTRATION

☑ **Belatacept** (Nulojix) in 0.9% sodium chloride, intravenous infusion, administer with 0.2-1.2 micron filter

- ☐ 10mg/kg Day 1, Day 5, end of week 2, 4, 8 and 12
  (Please indicate if patient has received any previous infusions)
- ☐ 5mg/kg end of week 16 and every 4 weeks thereafter
- Prescribed doses must be evenly divisible by 12.5mg
- Final concentration should range from 2mg/ml to 10mg/ml
- Administer over 30 minutes

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

*NULOJIX is contraindicated in transplant recipients who are Epstein-Barr virus (EBV) seronegative or with unknown EBV serostatus due to the risk of post-transplant lymphoproliferative disorder (PTLD), predominantly involving the central nervous system (CNS).

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

☐ BAY AREA: 844-899-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN: 888-615-1445
☐ CINCINNATI: 844-946-0868	☐ HARRISBURG: 844-859-4235	☐ KANSAS CITY: 844-900-1292	☐ TAMPA: 844-946-0849	☐ MIDDLE TN: 888-615-1445
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ ORLANDO: 844-946-0867	☐ WEST FLORIDA: 844-946-0849	☐ EAST TN: 888-615-1445