Belatacept (Nulojix)

Provider Order Form Revised 10/29/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:_____ Patient Name:_____ DOB:_____

ICD-10 code: ☐K50._____ ☐K51._____ ☐Other:_____

ICD 10 Description:_____

☐NKDA Allergies:_____Weight (lb/kg)_____

Patient Status: ☐ New to Therapy ☐New to Therapy Last Treatment Date:_____ Next Due Date:_____

PROVIDER INFORMATION

Referral Coordinator Name:_____ Referral Coordinator Email:_____

Ordering Provider:_____ Provider NPI:_____

Referring Practice Name:_____ Phone:_____ Fax:_____

Practice Address:_____ City:_____ State:_____Zip:_____

NURSING

☒ Provide TB status & date (list results and attach clinicals)

_____

☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI

☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every_____

☐ CMP ☐ at each dose ☐ every_____

☐ CRP ☐ at each dose ☐ every_____

☐ Other:_____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

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

☐ cetirizine (Zyrtec) 10 mg PO

☐ loratadine (Claritin) 10 mg PO

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

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

☐ hydrocortisone (Solu-Cortef) 100 mg IV

☐ Other:_____

Dose:_____ Route:_____

Frequency:_____

THERAPY ADMINISTRATION

☒ **Belatacept** (Nulojix) in 0.9% sodium chloride intravenous solution.

Patient's pre-transplat weight:_____**☐lb / ☐kg**

☐ 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 12.5 mg
- Final concentration: range from 2mg/mL to 10mg/mL
- Dosage will be based on pre-transplant weight. Dose will not be modified during treatment course, unless there is a change of >/< 10%

☒ **Route:** Intravenous

☒ **Rate:** Infuse over 30 minutes

☒ Flush with 0.9% sodium chloride after infusion completion

☐ Patient is required to stay for 30-minute observation post infusion

- Refills: ☐ Zero/ ☐ for 12 months/ ☐ Other:_____

(If not indicated, order will expire one year from date signed)

To ensure a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS

☐ Please check this box if you DO NOT authorize Redeemer Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

_____ _____ _____

Provider Name (Print) Provider Signature Date