Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 **DOB:**_____

Standard Plan of Treatment for NULOJIX

(Re)Certification Period from _____ to _____

NOTE: Patient is ***ineligible*** to receive Nulojix if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name: _____ _____ **Weight:** _____

Allergies: _____ **Height:** _____

Primary Diagnosis _____ Secondary Diagnosis: _____

NULOJIX is contraindicated in transplant recipients who are EBV seronegative or unknown serostatus.

Orders:

Obtain weight each visit. Vital Signs: baseline and every 30 minutes until infusion complete.
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.
Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line, followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.
Pump, tubing, and supplies needed to complete prescribed therapy.
If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Drug:

Weight on Transplant _____ *(Dose is calculated on transplant weight unless weight varies by ≥ 10%)*

Nulogix 5mg/kg IV in 100ml NS, administer over 30 minutes every 4 weeks

Labs: _____

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature: _____ / _____ Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920