MRN:_____

DOB:_____

STANDARD NULOJIX® (belatacept) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive belatacept if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, **new-onset or deterioration neurological changes**, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: □ Z94.0 Kidney Transplant Status

□ Other ICD-10 Code/Diagnosis description:_____

*** NULOJIX® (belatacept) is contraindicated in transplant recipients who are Epstein-Barr (EBV) seronegative or unknown serostatus.**

Dosing for Maintenance Phase:

NULOJIX® (belatacept) 5mg/kg in 100 ml Sodium Chloride 0.9% IV to infuse over a minimum of 30 minutes every 4 weeks with 0.22-micron filter, using a **silicone-free syringe** for reconstitution and preparation

4. Other: NULOJIX® Distribution Program (NDP) ID #: _____

Transplant Date:_____ Weight on Transplant: _____

(Dose is calculated on transplant weight unless weight varies by > 10%)

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing NULOJIX® (belatacept)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results, transplant summary note, and/or tests to support diagnosis.**

- NULOJIX is a selective T-cell costimulation blocker indicated for prophylaxis of organ rejection in adult patients receiving a kidney transplant. Treatment is used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids. Limitations of use: • **Use only in patients who are EBV seropositive.** • Use has not been established for the prophylaxis of organ rejection in transplanted organs other than the kidney.

☐ Last dose of Nulojix®, date: _____

☐ Other as requested: _____

_____

Pre-Screening:

☐ Patient enrolled into the NULOJIX® Distribution Program (NDP) via Bristol-Myers Squibb (BMS) by calling 1-855-511-6180 and completing enrollment paperwork. A Patient identification number from the NDP is required to order NULOJIX for new and existing patients. Patient specific ID #:_____.

☐ Documentation of Epstein-Barr virus (EBV) serology

☐ **Required TB screening results: PPD or QuantiFERON Gold Test within last 12 months**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

** **Warnings/Precautions:** Only physicians experienced in immunosuppressive therapy and management of kidney transplant patients should prescribe NULOJIX®. **Post-Transplant Lymphoproliferative Disorder (PTLD):** increased risk, predominantly involving the CNS; monitor for new or worsening neurological, cognitive, or behavioral signs and symptoms. **Other malignancies:** increased risk with all immunosuppressants; appears related to intensity and duration of use. Avoid prolonged exposure to UV light and sunlight**. Progressive Multifocal Leukoencephalopathy (PML):** increased risk; consider in the diagnosis of patients reporting new or worsening neurological, cognitive, or behavioral signs and symptoms. Recommended doses of immunosuppressants should not be exceeded. **Other serious infections:** increased risk of bacterial, viral, fungal, and protozoal infections, including opportunistic infections and tuberculosis. Some infections were fatal. Polyoma virus-associated nephropathy can lead to kidney graft loss. **Evaluate for tuberculosis and initiate treatment for latent infection prior to NULOJIX® use. Cytomegalovirus (CMV) and pneumocystis (PJP) prophylaxis are recommended after transplantation. Liver transplant:** use is not recommended due to an increased risk of graft loss and death. **Immunizations:** avoid use of live vaccines during treatment. **Coadministration with Anti-Thymocyte Globulin:** may pose a risk for venous thrombosis of the renal allograft. Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.