Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Nulojix® (belatacept) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:							
Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)	
☐	Z94.0 - Kidney Transplant Status
☐	_____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent H&P and Medication list	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Tried and failed therapies		NEXT INFUSION DATE:
4	Documentation of Epstein-Barr serology		**IF ORDER CHANGE:**
5	Lab results, transplant summary note, and/or tests to support diagnosis.		☐ **Continue current order until insurance approved**
6	TB screening results within last 12 months		

MEDICATION ORDERS:

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

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

DOSE/FREQUENCY:

☐ Maintenance: 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**

☐ Other: _____

NULOJIX® Distribution Program ID Number: _____

Required for weight based dosing: Transplant date:_____ Patient Transplant weight: _____

(Dose is calculated on transplant weight unless weight varies by > 10%, after which they will be dosed on actual body weight)

SPECIAL/LAB ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:	
PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023